

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE
JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038202

FILED VS NOV 3 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9775**

INDEXED

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 4 years	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Stone Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5416 Genevieve		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle H Last Weidanz			4. DATE OF DEATH Month Oct. Day 23 Year 1959		
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/4/1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Public Service		11. BIRTHPLACE (City and state or country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Adolph Weidanz		13b. MOTHER'S MAIDEN NAME Elizabeth Webberd	
14. NAME OF HUSBAND OR WIFE Louise Weidanz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 489 12 4760	
17. INFORMANT Erwin Weidanz		Address 5426 Genevieve			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia <i>Due to pneumonia</i>					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					491x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) debility from old age				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to 10/23/1959 and last saw him alive on 10/23/1959 Death occurred at 2 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE N. Kimelman (Degree or title) M.D.		22b. ADDRESS 809 1005 Hig Bend		22c. DATE SIGNED 12-29-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 10-26-1959	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
24. FUNERAL DIRECTOR Buchholz Mort. 5967 W. Florissant Av.		25. DATE RECD. BY LOCAL REG. OCT 26 1959		26. REGISTRAR'S SIGNATURE Head Smith, M.D. <i>S.O.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Kamelman
1025 Big River

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter J. Berak

Licensed Embalmer No. 4551

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.