

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

131-60-013505

FILED VS. MAR 3 0 1960

317 Primary Registration District No. 548 Registrar's No. 746

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webster Groves 19		Length of stay in 1b YRS	c. CITY OR TOWN Webster Groves Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 30 Algonquinwood Pl.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 30 Algonquinwood Pl. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HANS Middle WEICHSSEL Last			4. DATE OF DEATH Month March Day 3 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27 - 1877 - 83	9. AGE (last birthday) 83	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired consultant engineer, Wagner Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY Hildesheim Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.		

13a. FATHER'S NAME Bruno Weichsel	13b. MOTHER'S MAIDEN NAME Helene Schneider	14. NAME OF HUSBAND OR WIFE Alice Knapp Weichsel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. unk	17. INFORMANT Address Mrs. Alice K. Weichsel 30 Algonquinwood Pl.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Bronchial Pneumonia.		few days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Hemorrhage (2nd).	10 days.
	DUE TO (c) Generalized Arterio-sclerosis.	1 yr.
	Paralysis left arm & leg since 1st hemorrhage	years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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"/>	20e. 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 **9/25/49** to **Mar 3 1960** and last saw her alive on **Feb 24 1960**.
Death occurred at **1030 or 11 am 3/3/60** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. Victor Reese M.D.	22b. ADDRESS 120 E. Rockwood No. Webster Groves	22c. DATE SIGNED 3/4/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-5-1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar Blv'd.		23d. LOCATION (City, town, or county) (State) St. Louis Missouri.

25. DATE RECD. BY LOCAL REG. 3-4-60	26. REGISTRAR'S SIGNATURE J. B. Murphy M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

Arnold W. Schoe

Licensed Embalmer No. 3864

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.