

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-025075

FILED VS JUN 29 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5736**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2yr. 8mo. 18days	c. CITY OR TOWN Ladue Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) #3 Black Creek Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mae Middle Weingarten Last Weingarten			4. DATE OF DEATH Month 6 Day 1 Year 60
5. SEX Female	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 5/1/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) Covington, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James Cassidy		13b. MOTHER'S MAIDEN NAME Mary Cassidy	14. NAME OF HUSBAND OR WIFE George S.
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. Nil.	17. INFORMANT Address Records Chronic Hospital 5800 Arsenal., St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 420.0 DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bronchopneumonia - 4 days.			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" 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 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 10-14-57 to 6-1-60 and last saw her/him alive on 6-1-60 Death occurred at 6:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John W. Beckham M.D.		22b. ADDRESS 5800 Arsenal	22c. DATE SIGNED 6/1/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-3-60	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Mo. (State)
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. JUN 3 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WOC

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 George W. Wickman

Licensed Embalmer No. 357

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.