

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9670-62-040860  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9670**

**FILED OCT 19 1962**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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DOCUMENT

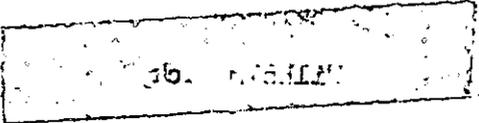
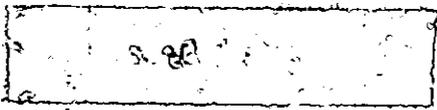
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|  |                                  |   |  |   |   |  |  |  |
|--|----------------------------------|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MO</b>  |                                  |   | Length of stay in 1b   |   | c. CITY OR TOWN <b>St. Louis</b>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>   |                                  |   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location)<br><b>1420 Mississippi</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ADOLPH</b> Middle <b>WECK</b> Last   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>OCT.</b> Day <b>8.</b> Year <b>1962</b>  |   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/3/1902</b>  | 9. AGE (last birthday)<br><b>60</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HR   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Bricklayer</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Blue Earth Minnesota</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>U.S.</b>   |  | 12. CITIZEN OF WHAT COUNTRY  |  |
| 13a. FATHER'S NAME<br><b>Wilhelm Weck</b>  |                                  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Ida Arndt</b>  |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>unavailable</b>                        |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>  |   | 17. INFORMANT Address<br><b>Waldemar Weck 1221 Frank, Albert Lea, Minn</b>                                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |                                  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>  |                                  |   |  |   |   |  |  |  |
| DUE TO (b) <b>AORTIC INSUFFICIENCY</b>   |                                  |   |  |   |   |  |  |  |
| DUE TO (c) <b>?? RHEUMATIC HEART DISEASE</b>   |                                  |   |  |   |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>PULMONARY EMBOL.</b> |                                  |   |  |   |   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>411X</b> |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.  |                                  |   | 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 <b>10/4/62</b> to <b>10/8/62</b> and last saw her/him alive on <b>10/8/62</b>   |                                  |   | Death occurred at <b>6:40 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>J. E. Smith M.D.</b>  |                                  |   |  | 22b. ADDRESS<br><b>1515 LAFAYETTE AVE</b>   |   |  | 22c. DATE SIGNED<br><b>10/8/62</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 23b. DATE<br><b>10-9-62</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakewood Cem</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Albert Lea, Minn.</b>                                   |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>  |                                  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>OCT 9 1962</b>   |   | 25. REGISTRAR'S SIGNATURE<br><b>Earl Smith. M.D.</b>                     |  |  |

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**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 Harvey Kahl

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

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.