

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-022824**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1480

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED JUN 5 1963</b>	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton Richmond HTS.</u> Length of stay in 1b <u>2 days</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5521a Chippewa St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>HERMAN</u> Middle <u>A.</u> Last <u>WEINRICH</u>	
<b>4. DATE OF DEATH</b> <u>May 5, 1963</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>
<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/30/1883</u>
<b>9. AGE</b> (last birthday) <u>79</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>retired school teacher</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Religious instruction</u>
<b>11. BIRTHPLACE</b> (City and state or country) <u>New Melle, Mo.</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Christian Weinrich</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>unk.</u>
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Louise Kahre</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of serv.) <u>no</u>	
<b>17. INFORMANT</b> <u>Mrs. Norma L. Frank, 7344 Pershing Ave.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Thrombosis of coronary artery</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> <u>4200</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Congestive heart failure</u> 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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____
<b>21.</b> I attended the deceased from <u>May 1, 1963</u> to <u>May 5, 1963</u> and last saw <sup>her</sup> him alive on <u>May 4, 1963</u> . Death occurred at <u>7:30 A.</u> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)	<b>22b. ADDRESS</b> <u>16 Hampton Village</u>
<b>22c. DATE SIGNED</b> <u>5/6/63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>removal</u>	<b>23b. DATE</b> <u>5/8/63</u>
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Concordia Cemetery</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis, Missouri</u>	
<b>24. FUNERAL DIRECTOR</b> <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>5-6-63</u>
<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

Rev. O. B. Buckel  
#16 Hampton Village

**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 

Licensed Embalmer No. 4520  
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.