

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-042468

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 3147

STATE FILE NUMBER

FILED OCT 30 1963

VS 300
Rev. 4/59

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DATE AMENDED									
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KIRKWOOD</u>		Length of stay in lb <u>2 wks</u>	c. CITY OR TOWN <u>CRESCENT</u> <u>Mo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST JOSEPHS HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE ALBERT WEBER</u>			4. DATE OF DEATH Month Day Year <u>10/12/1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLORIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAISING FLOWERS</u>	9. AGE (last birthday) <u>63</u>
11a. FATHER'S NAME <u>FERDINAND WEBER</u>		11b. MOTHER'S MAIDEN NAME <u>GRACE CROMWELL</u>	11. BIRTHPLACE (City and state or country) <u>HOUSE SPRINGS Mo</u>
13a. FATHER'S NAME <u>FERDINAND WEBER</u>		13b. MOTHER'S MAIDEN NAME <u>GRACE CROMWELL</u>	14. NAME OF HUSBAND OR WIFE <u>ADA HEIGHT</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCE (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		16. Y NO. <u>156</u>	17. INFORMANT Address <u>CLARENCE WEBER Crescent Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			
DUE TO (c) _____			
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"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <u>Sept 16, 1963</u> to <u>Oct. 12, 1963</u> and last saw ^{him} alive on <u>Oct 12, 1963</u> Death occurred at <u>10:20</u> <u>am</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles E. Hogancamp, M.D.</u>		22b. ADDRESS <u>135 W. Adams Ave, Kirkwood 22, Mo.</u>	22c. DATE SIGNED <u>Oct 14, 1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>10/15/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Quehadg Queen of Peace House Springs Mo</u>	
23d. LOCATION (City, town, or county) <u>Mo</u>		23e. (State)	
24. FUNERAL DIRECTOR ADDRESS <u>BRIMMER FUNERAL HOME HOUSE SPRINGS</u>		25. DATE RECD. BY LOCAL REG. <u>10-14-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Herbert J. San Jr

Licensed Embalmer No. 4800

P. O. Address Liberal 27 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.