

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

~~21503~~
21431
File No. _____
Registered No. **6308**
St. _____ Ward)

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis** (No. **Jewish Hos'p**)

2. FULL NAME

Leopold Adolph Weil

(a) Residence, No. **5744 Bartmer Ave. St.** **5** Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male white married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Ray Stein

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept, 12, 1863**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
66 9 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Insurance agency**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Raphael Weil**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **France**

12. MAIDEN NAME OF MOTHER **Johanna Pfeiffer**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Mrs. L. Weil**
(Address) **5744 Bartmer Ave**

15. FILED **20 1930** **W. C. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 27 1930**

17. I HEREBY CERTIFY, That I attended deceased from **June 16**, 19**30**, to **June 27**, 19**30**, that I last saw h. **alive** on **June 27**, 19**30**, and that death occurred, on the date stated above, at **4:30 a. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

107A
Broncho-pneumonia
(duration) yrs. mos. **20** ds.

CONTRIBUTORY (SECONDARY) **1000**
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? **No.** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **X-Ray**
(Signed) **Lowell G. Sale, M. D.**

6/28, 19**30** (Address) **3720 Washington**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mt. Sinai 6/30/30

20. UNDERTAKER ADDRESS - **Wayer 4356 Lindell Bl**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

