

JUL 10 1937

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

Do not use this space.

22887

1. PLACE OF DEATH

County Jackson
Township Kear
City Ice

Registration District No. 399
Primary Registration District No. 1002
(No. 503 Monroe)

File No. _____
Registered No. 503
St. Monroe Ward _____

2. FULL NAME

(a) Residence, No. 503 Monroe St. _____ 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 M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (widow) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17 - 1878

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
58 8 5

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Millwright

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wis

13. NAME John Weber

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Helen Weber (ADDRESS) 503 Monroe

18. BURIAL, CREMATION, OR REMOVAL PLACE St Marys DATE June 25 37

19. UNDERTAKER Dr. Drexler (ADDRESS) 1915 215

20. FILED 6/23 37 1937 M. M. Cox Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 22, 1937

22. I HEREBY CERTIFY That I attended deceased from _____, 19____

I last saw him _____ live on _____, 19____ Death is said

to have occurred on the date stated above, at 9 9 a. m.

The principal cause of death and related causes of importance were as follows:

Chronic thrombosis Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) [Signature], M. D.

(Address) [Address]

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.

