

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

16519  
Do not use this space.

**1. PLACE OF DEATH**

(a) County..... / Registration District No..... **1008**  
 (b) Township..... / Primary Registration District No..... Registered No..... **4053**  
 (c) City..... **St Louis** / (d) Street No..... **St John's Hospital** St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No..... **4119 Lexington Ave** St. **10** (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William F Weber**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 29th 1874**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
**64 11 2**

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**  
 9. Industry or business in which work was done, as 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)..... **Germany** (STATE OR COUNTRY) **6**

13. NAME **Unknown** **9**

14. BIRTHPLACE (CITY OR TOWN)..... **Unknown** (STATE OR COUNTRY) **9**

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Adeline Weber** (ADDRESS) **5535 Cates Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **May 3rd 1939**

19. FUNERAL DIRECTOR (NAME) **Stroet - Carroll** (ADDRESS) **4600 Natural Bridge Ave**

20. FILED **MAY 2 1939** **J. B. Budick** Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 1st 39**

22. I HEREBY CERTIFY, That I attended deceased from **Apr 7, 1939** to **May 1, 1939**  
 I last saw h. **alive on Apr 30, 1939** Death is said to have occurred on the date stated above, at **3:45a**  
 The principal cause of death and related causes of importance were as follows:

*Coronary Artery III left Branch*  
 Date of onset

Other contributory causes of importance:

Name of operation **Resection** Date of **4-28-39**  
 What test confirmed diagnosis? **Biopsy** as 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? **Yes**  
 If so, specify..... (Signed) **J. B. Budick**  
 (Address) **517 S. Raymond**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

50X-9-1033 I X18605

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address .....

**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 this body is not embalmed, above space should be left blank.**