

10 1939

REC'D JUN 8 1939

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

19729
Do not use this space.

1. PLACE OF DEATH

(a) County ST. LOUIS Registration District No. 784

(b) Township ST. FERDINAND Primary Registration District No. 905

(c) City or JENNINGS (d) Street No. 2036 BELLE St.

(e) Length of residence in city or town where death occurred 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 38 yrs. mos. ds.

2. PRINT FULL NAME SIMON WEIKER

(a) Residence, No. 2036 BELLE St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) unk.

7. AGE YEARS about 63 MONTHS DAYS If LESS than 1 day,hrs. ormin.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. D. K

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) unk. Total time (years) spent in this occupation unk.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 8 1939

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, 3:30 P. m.

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

SUICIDE BY FIREARMS (REVOLVER) Date of onset 5/8/39

Other contributory causes of importance: Gun shot wound thru the head 167 Date 5/8/39

Name of operation..... Date of.....

What test confirmed diagnosis? PHYSICAL Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide SUICIDE Date of injury 5/8 1939

Where did injury occur? JENNINGS, Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Home

Manner of injury Suicide by firearms

Nature of injury g/s wound of head

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify John O'Connell, M. D. (Signature)

(Address) Farmers & Merchants Bank

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

FATHER

13. NAME SIMON WEIKER

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) MARY WEIKER
2036 BELLE

18. BURIAL, CREMATION, OR REMOVAL PLACE CALVARY DATE May 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Farmer
6147 National Bridge Rd.

20. FILED MAY 10 1939 W. R. Meyer Local Registrar

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.

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.....

L B Tanner

Licensed Embalmer No.....

2422

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.