

S. No. 2
1-11-10-39
ev. 5-17-39
I X21492

FILED SEP 25 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 27026
Registrar's No. 6922

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1719 Iowa, Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Fanny Weis
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Weis 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased Feb. 10 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 6 4 _____ hr. _____ min.

9. Birthplace Bohemia
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Robinek
13. Birthplace Bohemia
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Weis
(b) Address 1719 Iowa, Ave.

17. (a) Burial (b) Date thereof 8/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Picker

18. (a) Signature of funeral director J. C. Moydell
(b) Address 1926 Allen, Ave.

19. (a) AUG 16 1940 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 23
(If outside city or town limit, write "RURAL")
(d) Street No. 1719 Iowa Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 14
year 1940 hour 8 minute 45 p.m.

21. I hereby certify that I attended the deceased from Aug. 12
1940 to Aug 14, 1940;
that I last saw her alive on Aug 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage (2nd attack) Duration 2 days
Due to arteriosclerosis @ hyperten-sion many years

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: none
Of operations none
Of autopsy no

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature Wm. W. D. ... (M. D. or other) _____
Address 1040 Ernest Date signed 8/15/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Benj. C. Duman
Licensed Embalmer No. 2272
P. O. Address 1926 Allen

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.