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FILED JUL 11 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22591

State File No. _____

Registration District No. 773

Primary Registration District No. 6018A

Registrar's No. 109

1. PLACE OF DEATH:

(a) County St. Francois St. Francois
(b) City or town St. James
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital No. 49
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 2 months - 16 days
years, months or days)

3. (a) PRINT FULL NAME Caroline Weiden
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wendell Weiden 6. (c) Age of husband or wife if alive U.K. years
7. Birth date of deceased February 5 1861
(Month) (Day) (Year)

8. AGE: Years 90 Months 4 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Susan
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Susan
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Records St. Joseph's Hospital No. 4
(b) Address St. James, Missouri
17. (a) Buried (b) Date thereof July 1 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation no record

18. (a) Signature of funeral director Leol. Basler
(b) Address St. James, Mo
19. (a) 7-10-41 (b) 73.8. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Genevieve
(c) City or town St. Genevieve
(If outside city or town limits, write "RURAL")
(d) Street No. Route 2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1941 hour 7 minute 15 p. M.
21. I hereby certify that I attended the deceased from March 12, 1941, to June 28, 1941;
that I last saw her alive on June 28, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis generalized & marked Duration ?

Due to _____
Due to _____

Other conditions Senile psychosis, dependent
(Include pregnancy within 3 months of death)

Major findings: And agitated type PHYSICIAN _____
Of operations None operation Underline the cause to which death should be charged statistically.
Of autopsy no autopsy

22. If death was due to external causes, fill in the following:
(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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M.D. or other) M.D.
Address St. James, Mo Date signed 7/2/41

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 Leo C. Butler

Licensed Embalmer No. 1985

P. O. Address Ste. Genevieve, Mo.

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, fact should be so stated above.