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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NEW AUG 6 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23229

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 6418

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town St Louis
(c) Name of hospital or institution 3225 Montgomery
(d) Length of stay: In hospital or institution

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County 000
(c) City or town St Louis 17
(d) Street No. 3225 Montgomery 910
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Philip Weil
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 22
year 1942 hour 6 minute 30 A.M.

4. Sex male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: M (Month) 1862 (Day) (Year)

21. I hereby certify that I attended the deceased from
to, 19 to, 19
that I last saw him alive on
and that death occurred on the date and hour stated above.

8. AGE: Years 80 Months Days If less than one day hr min

Immediate cause of death
Coronary Sclerosis
Arterio sclerosis

9. Birthplace: M O O (City, town, or county) (State or foreign country)

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Brick layer
11. Industry or business

Major findings:
Of operations
Of autopsy

MOTHER FATHER
12. Name
13. Birthplace
14. Maiden name
15. Birthplace

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

16. (a) Informant
(b) Address
17. (a) Date thereof 7-16-42
(b) Place: burial or cremation

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director
(b) Address
19. (a) (b) Registrar's signature

23. Signature (M. D. or other)
Address Date signed

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp. the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 6418

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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

2. USUAL RESIDENCE OF DECEASED:

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

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1942 Minute _____ M. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

Immediate cause of death _____ Duration _____

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ min.

Due to _____
Due to _____

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

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

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

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof 7-16-42 (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) SEP 9 1942 (b) J. F. Brubaker
(Date received local registrar) (Registrar's signature)

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)

While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

S-23229