

S. No. 2
DM-5-42
v. 5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16733

State File No. _____

Registrar's No. **4431**

D MAY 19 1943

318

1003

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:
St. Anthony's Hospital
(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 **Missouri** (b) County _____

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3323 Halliday Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Gustave Weise**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **494-07-9168**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **6**
year **1943** hour **11** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **April 25-1943**
to **May 6, 1943**
that I last saw him alive on **May 6, 1943**
and that death occurred on the date and hour stated above.

4. Sex **Male** Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lottie Weise**

6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **Sept. 1, 1872**
(Month) (Day) (Year)

Immediate cause of death _____

Due to **arterio sclerosis**

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

8. AGE: Years **70** Months **8** Days **5**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

Major findings: **Sept of coronary artery**

Of operations **None**

Of autopsy **None**

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

10. Usual occupation **Stove Mounter**

11. Industry or business _____

MOTHER FATHER { 12. Name **Louis Weise**

13. Birthplace **New York New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Don't know**

15. Birthplace **Don't know**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **no**

(b) Date of occurrence **no**

(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 _____

16. (a) Informant **Mrs. Lottie Weise**

(b) Address **3323 Halliday**

17. (a) **Burial** (b) Date thereof **5/12/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Mausoleum**

18. (a) Signature of funeral director **Weick Bros.**

(b) Address **2201 S. Grand Bl.**

19. (a) **MAY 12 1943** **J. J. Predest**
(Date received local registrar) (Registrar's signature)

23. Signature **W. Schneider** (M. D. or other) **W. Kels**

Address **3318 1/2 Grand** Date signed **5-11-43**

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

Dr. Schneider
S. Howard
3318 S. Howard

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 Nancy A. Stewart

Licensed Embalmer No. 3722

P. O. Address 412 Duchouquette St.

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.