

NOV 5 1943  
Registration District No. **116**

Primary Registration District No. **3020**

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

**1. PLACE OF DEATH:**  
 (a) County Franklin  
 (b) City or town Washington  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15  
3 years (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Hugo J. Weil  
**3. (b) If veteran, name war** \_\_\_\_\_ **3. (c) Social Security No.** 49-10-1832

**4. Sex** Male **5. Color or race** White  
**6. (a) Single, widowed, married, divorced** Married  
**6. (b) Name of husband or wife** Millicuet Weil **6. (c) Age of husband or wife if alive** 51 years  
**7. Birth date of deceased** Sept. 23, 1889  
(Month) (Day) (Year)

**8. AGE:** Years 54 Months -- Days 15  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Franklin, Iowa  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Foreman Shoe Factory

**11. Industry or business** \_\_\_\_\_

**MOTHER FATHER**  
**12. Name** George Weil  
**13. Birthplace** Unknown  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Ernestine Mechnick  
**15. Birthplace** Germany  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Mrs. Mellicuet Weil  
**(b) Address** Union, Missouri

**17. (a) Removal** (Burial, cremation, or removal) **(b) Date thereof** 10-9-43  
(Month) (Day) (Year)

**(c) Place: burial or cremation** Keokuk, Iowa

**18. (a) Signature of funeral director** W. J. Horn

**(b) Address** Union, Mo.

**19. (a)** 10/10/43 **(b)** Lurel Kutha Brook  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Franklin  
 (c) City or town Union  
(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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month 10 day 8  
 year 1943 hour 8 minute 35 M.

**21. I hereby certify that I attended the deceased from** 9-22, 1943 to 10-8, 1943  
 that I last saw him alive on 10-7  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis  
Chronic Myocarditis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions: Diabetes Mellitus  
(Include pregnancy within 3 months of death)

**Major findings:**  
 Of operations \_\_\_\_\_  
 Of autopsy U

**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** Wm. J. Horn (M. D. or other)  
 Address Union, Mo. Date signed 10-8-43

Duration 2 wks.  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

NOV - 7 1949

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**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..... *W. H. H. H. H.*  
Licensed Embalmer No. *3175*  
P. O. Address..... *Union, Wis*

**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.**