

FILED JUN 19 1945

Registration District No. 377

Primary Registration District No. 6076

Registrar's No. 1087

1. PLACE OF DEATH:

(a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Mar. 26, 1945
(Specify whether
In this community three years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis Co.,
(c) City or town Lemay
(If outside city or town limits, write "RURAL")
(d) Street No. Route #11, Box 670,
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

FREDERICK H. WEITLICH

3. (b) If veteran, name war World War #1
3. (c) Social Security No. 498-16-8467

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 May 28, 1893
(Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 7 If less than one day hr. min.

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business _____

12. Name Frank Weitlich

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

14. Maiden name Name unavailable

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

16. (a) Informant Clinical Records

(b) Address Vet. Adm. Fac., Jeff. Brks., Mo.

17. (a) REMOVAL (b) Date thereof MAY 7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. JOSEPH, MO. RAIL

18. (a) Signature of funeral director C. HOFFMEISTER UIC

(b) Address 7814 S. BRONDAWAY

19. (a) MAY 9 1945 (b) E. B. Mc Borden
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th,
year 1945 hour 12:15 minute P. M.

21. I hereby certify that I attended the deceased from March 26, 1945, to May 5, 1945
and that death occurred on the date and hour stated above.
that I last saw him alive on May 5, 1945

Immediate cause of death: NEPHRITIS, CHRONIC, Duration Unknown

Due to - 131a

Due to -

Other conditions: Hypertension, arterial. Unknown
(Include pregnancy within 3 months of death)

Major findings: No operation. PHYSICIAN
Of operations

Of autopsy: No autopsy.
Underline the cause to which death should be charged statistically.

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

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

(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 E. V. EDWARDS, MAJOR, M.C. (M. D. or other)
Address CLINICAL DIRECTOR Date signed 5/5/45

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

JUN 22 1945

JUL 31 1945

SEP 20 1945

REC 11 1953

JUN 27 1945

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 *Louis C. Hoffmeister*

Licensed Embalmer No. *3877*

P. O. Address *7814 S Broadway*

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.