

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

FILED OCT 19 1945
Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. 8537

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
4201 Utah St.
(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

3. (a) PRINT FULL NAME Caroline Weiler

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

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Joseph

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

7. Birth date of deceased Jan. 30 1853
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>7</u>	<u>28</u>	hr. _____ min. _____

9. Birthplace Ste. Genevieve Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Florian Huck

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

14. Maiden name Mary Fischer

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

16. (a) Informant Mrs. Edw. Will

(b) Address 4201 Utah St.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 10-2-45
(Month) (Day) (Year)

(c) Place: burial or cremation Ste. Genevieve, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) OCT 2 1945
(Date received local registrar)

J. F. Bredeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 4201 Utah St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28
year 1945 hour 70.00 minute _____

21. I hereby certify that I attended the deceased from Aug 5, 1945
to Sept 28, 1945

I last saw her alive on Sept 28
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Arterial Sclerosis

Due to _____

Due to _____

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

Duration

PHYSICIAN

Major findings:
Of operations _____

Of 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) _____

(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 A. F. Plag (M. D. or D.O.)

Address 3150 Morganfield Date signed 10/1/45

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 *Elmo R. Padwell*.....

Licensed Embalmer No. *4077*.....

P. O. Address.....

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.