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#54688

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED MAR 20 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. 11792
2426

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(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 CORA WEIL

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Erastus

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

7. Birth date of deceased: Dec 12 1881
(Month) (Day) (Year)

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

64 3 0 hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business at Home

MOTHER FATHER { 12. Name Unknown Hackmann H

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

14. Maiden name Unknown Keller

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

16. (a) Informant Raymond Weil

(b) Address 4134 Maryland Ave

17. (a) Burial (b) Date thereof 3 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cemetery

18. (a) Signature of funeral director Kriegshauser

(b) Address 4228 So. Kingshighway

19. (a) MAR 13 1946 J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County soo

(c) City or town St. Louis 187
(If outside city or town limits, write "RURAL")

(d) Street No. 4134 Maryland Ave
Memorial (If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 12th
year 1946 hour 9:40 minute A M.

21. I hereby certify that I attended the deceased from 2/28/46
_____ 19 _____ to 3/12/46 19 _____

that I last saw her er alive on 3/12/46 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary thromboses

Due to Left femoral thrombophlebitis

Due to Left hemiplegia due to arteriosclerotic cerebral vascular disease

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy above

Duration

PHYSICIAN

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 W. Hamilton 3/12/46
Address 1515 Lafayette Date signed _____

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 Colin J Mc Dermott

Licensed Embalmer No. 3024

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.