

No. 2
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-17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36389**
9276
Registrar's No.

FILED OCT 24 1947
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: MO. PACIFIC HOSP. O
(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 ILLINOIS (b) County MARION 999
(c) City or town CENTRALIA
(If outside city or town limits, write "RURAL")
(d) Street No. 236 N. MAPLE AV. O
W.R. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME Weber, Lee

3. (b) If veteran, _____ name war. _____ 3. (c) Social Security No. 702-12-4347

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 FEB 10 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 7 20 hr. min.

9. Birthplace CARLYLE ILL.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business RAILRODDEER

12. Name AMBROSE WEBER

13. Birthplace _____ GERMANY 4
(City, town, or county) (State or foreign country)

14. Maiden name MARY CAFFERY

15. Birthplace _____ IRELAND 4
(City, town, or county) (State or foreign country)

16. (a) Informant MR. PETA GARNIER

(b) Address CENTRALIA ILL.

17. (a) REMOVAL (b) Date thereof 10-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CENTRALIA ILL.

18. (a) Signature of funeral director ROWLAND FUNERAL COR.

(b) Address OCT 7 1947 WASHINGTON, MO.

19. (a) _____ (b) J. F. Bradeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30
year 1947 hour 5 minute 35 P. M.
21. I hereby certify that I attended the deceased from Sept. 17, 1947 to Sept 30, 1947
that I last saw him alive on Sept. 30, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Infarction
Duration _____

Due to chronic Myocarditis & Auricular Fibrillation

Due to _____
Other conditions Fracture, Left Humerus
(Include pregnancy within 3 months of death)

Major findings: Did not contribute to the cause of death
Of operations _____
Of autopsy _____
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? _____

23. Signature Vincent A. Sherrod (Specify type of place) _____ (c) Means of injury _____

(M. D. _____) Address Mo. Pac. Hosp. Date signed 9-20-47

OCT 7 1947

(Licensed Embalmer's Statement on Reverse Side)

Dr Sherrod

9276

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.....

Law M. Sizemore

Licensed Embalmer No.

4343

P. O. Address.....

St. Louis, Mo.

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.