

FILED JUN 15 1948

Registration District No. \_\_\_\_\_ Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Baden Station  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Halls Ferry Memorial Hospital  
(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 Edward Claude Westaver

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bertha R. Westaver 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased 8/30/1882  
(Month) (Day) (Year)

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

<u>67</u>	<u>8</u>	<u>20</u>	hr. _____ min. _____
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9. Birthplace Topeka Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Physician M.D.

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

MOTHER FATHER { 12. Name John E. Westaver

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

14. Maiden name Minnie White

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

16. (a) Informant Mrs. Edward Westaver

(b) Address 8017 Madison Ave Vinita Park

17. (a) Cremation (b) Date thereof 5/21/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Chapel

18. (a) Signature of funeral director Robert J. Ambruster Inc

(b) Address 6633 Clayton Road

19. (a) 5-23-48 (b) Carley Shook MO  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Winita Park 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. 8017 Madison Ave 0  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20th  
year 1948 hour 10.20 minute P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to 5/20/48, 19\_\_\_\_.

that I last saw him alive on 5/20/48, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arterio Sclerosis

Due to 830

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 H. S. Hall (M. D. or other) U

Address 2739 N. Grand Ave Date signed 5/22/48

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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 Ernest W. Spillars

Licensed Embalmer No. 14080

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.**