

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39553

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 429

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>                                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) <u>15 OR TOWN Pine Lawn</u> <u>96</u>                                   |  |
| c. LENGTH OF STAY (in this place) <u>4 days</u>                                     |  | d. STREET ADDRESS (If rural, give location) <u>4240 Edgewood</u> <u>06</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u>               |  |  |  |

|   |                               |   |  |   |
|---|-------------------------------|---|--|---|
| 3. NAME OF DECEASED<br>(Type or Print) <u>MARY</u>  |                               |   | 4. DATE OF DEATH <u>11/15/49</u>                                     |   |
| a. (First)  | b. (Middle)                   | c. (Last) <u>WEBER</u>  |  | (Month) (Day) (Year)                      |
| 5. SEX <u>Female</u>  | 6. COLOR OF RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 25, 1886</u>                                | 9. AGE (In years last birthday) <u>63</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>                          | 11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |

|                                       |   |   |
|---------------------------------------|---|---|
| 13a. FATHER'S NAME <u>Joseph Haas</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Kraus</u> | 14. NAME OF HUSBAND OR WIFE <u>George</u> |
|---------------------------------------|---|---|

|  |  |   |   |
|--|--|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>489-20-5433</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>George Weber</u> | ADDRESS <u>4240 Edgewood Ave. Pine Lawn, Mo</u> |
|--|--|---|---|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral embolus</u>  |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO (c) <u>auricular fibrillation and mural thrombus in auricles</u> <u>pg. 21</u> |  |   |

|                        |   |  |
|------------------------|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>422.1</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|---|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from 11-12-, 1949, to 11-15-, 1949, that I last saw the deceased alive on 11-15-, 1949, and that death occurred at 10:40 a.m., from the causes and on the date stated above.

|  |                   |  |                                  |
|--|-------------------|--|----------------------------------|
| 23a. SIGNATURE <u>R. R. Cahle M.D.</u> | (Degree or title) | 23b. ADDRESS <u>601 Brentwood, Clayton</u> | 23c. DATE SIGNED <u>11-15-49</u> |
|--|-------------------|--|----------------------------------|

|   |                           |  |  |
|---|---------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>11/19/49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u> |
|---|---------------------------|--|--|

|   |  |  |                             |
|---|--|--|-----------------------------|
| DATE REC'D BY LOCAL REG <u>Nov 19, 1949</u> | REGISTRAR'S SIGNATURE <u>Harbert R. Stomke, M.D.</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wacker - Heldele</u> | ADDRESS <u>3634 Gravois</u> |
|---|--|--|-----------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Delis J. Krupin

Licensed Embalmer No. 3497

P. O. Address 3634 Gravois

**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.