S. No. 300
10-48

MAY 3 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15230

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1077

4000
4

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

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Manchester
c. LENGTH OF STAY (in this place) 13 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Manchester Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Manchester
d. STREET ADDRESS (If rural, give location) Manchester Nursing Home

4740
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3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle)
c. (Last) WEIKER

4. DATE OF DEATH (Month) (Day) (Year) April 13, 1952

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Apr. 6, 1876
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months 0 Days 7 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Kleinstadt, Austria 4
12. CITIZEN OF WHAT COUNTRY? ?

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Simon Weiker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Records ADDRESS St. Louis County Social Service

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Myocarditis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen'l arteriosclerosis
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 4-1-1
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1946, *to* Apr 13, 1952, *that I last saw the deceased alive on* Apr 12, 1952, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) C H Denny MD
23b. ADDRESS Creve Coeur, Mo
23c. DATE SIGNED 4-16-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4-19-52
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 4-23-52
REGISTRAR'S SIGNATURE Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS 4104 Manchester Ave.

SW (Licensed Embalmer's Statement on Reverse Side)

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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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed .....

Licensed Embalmer No. .....

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.