

FILED NOV 19 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41350**
10388
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 6154 Leona	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Anton W. L. Weber b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Oct. 31, 1953		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 1-18-1876	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Germany	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Unk. Weber		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Helen K. Weber	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. unk	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Viola Brettelle	
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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 6154 Leona			INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Insuff. & acute ischemia			3 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial infarction. DUE TO (c)			2 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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 4.201
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22. I hereby certify that I attended the deceased from **10-28**, 1953, to **10-31**, 1953, that I last saw the deceased alive on **10-31**, 1953, and that death occurred at **555p** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Severus H. Eddele, M.D.	23b. ADDRESS 4971 Chippewa St	23c. DATE SIGNED 11-2-53
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24a. BURIAL, CREMATION, OR REMOVAL (Specify)	24b. DATE 11-3-53	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum	24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.
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DATE REC'D BY LOCAL REG. NOV 2 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Blvd.
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Dr. E. Edele
4971 Chippewa
12 to 3 p.m.

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 David Van Fossen

Licensed Embalmer No. 4242

P. O. Address 6527 So Grand

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.