

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3407**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0595**

1. PLACE OF DEATH a. COUNTY 2		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 5400 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) EDITH b. (Middle) B c. (Last) WEBER		4. DATE OF DEATH (Month) (Day) (Year) Jan. 13, 1954	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 4/11/02
9. AGE (In years last birthday) 51		IF UNDER 1 YEAR Months 9	IF UNDER 1 HRS. Days 2 Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Carl Wagner	
13b. MOTHER'S MAIDEN NAME not known		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS 5400 Arsenal St.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 237X		22. I hereby certify that I attended the deceased from Jan. 1, 1953 , to Jan. 13, 1954 , that I last saw the deceased alive on Jan. 13, 1954 , and that death occurred at 9:20p m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Betty Harris Semon, M.D.		23b. ADDRESS 5400 Arsenal St.	
23c. DATE SIGNED 1/15/54		24a. BURIAL, CREMATION, REMOVAL (Specify) 1-30-54	
24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service ADDRESS 410 Manchester Ave. St. Louis 19, Mo.	
DATE REC'D BY LOCAL REG. JAN 20 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.