

No. 300
10,48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7117**

BIRTH NO. FILED FEB 18 1954 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 236

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CLAYTON		c. CITY OR TOWN JENNINGS #138 0	
c. LENGTH OF STAY (In this place) 5 DAYS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS COUNTY HOSPITAL		e. STREET ADDRESS (If rural, give location) 2345 SHANNON AVE.	

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) J. c. (Last) Webber			4. DATE OF DEATH (Month) (Day) (Year) 1-24-54		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	
8. DATE OF BIRTH APR. 29TH 1884		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TAVERN OWNER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME CONRAD VON WEBBER		13b. MOTHER'S MAIDEN NAME CATHERINE CABR		14. NAME OF HUSBAND OR WIFE LATE AUGUSTINE WEBBER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. GRACE CONNELLY, 2335 SHANNON AVE.	

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) Bilateral bronchopneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Thrombosis DUE TO (c) Generalized atherosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left leg thrombophlebitis		INTERVAL BETWEEN ONSET AND DEATH 4 days 5-6 days 1 yr. 1 yr	
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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?	

22. I hereby certify that I attended the deceased from **1-20-1954** to **1-24-1954**, that I last saw the deceased alive on **1-24-1954**, and that death occurred at **2:56 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Halter A. Nixon		23b. ADDRESS 22601 S. Brentwood, Clayton		23c. DATE SIGNED 1-24-1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 1/27/54		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
				24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	

DATE REC'D BY LOCAL REG. 1/26/54		REGISTRAR'S SIGNATURE Heber K. Spoke, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALVIN F. FEUTZ, 4828 NATURAL BRIDGE BL.	
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(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.....
Signature of Student Embalmer

Signed *John A. Mlinar*.....

Licensed Embalmer No. *4186*

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.