

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 6 - 1957

318

1003

STATE FILE NUMBER

15437

3727

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webster Groves</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Length of stay in lb <u>9</u>	d. STREET ADDRESS <u>409 Newport</u>			(If outside, give location) <u>400 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>ISAAC</u> Last <u>WEBER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1898</u>		9. AGE (In years - last birthday) <u>59</u> 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) <u>Insurance Broker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Bankers Life</u>		11. BIRTHPLACE (City and state or country) <u>Cairo, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Julius E. Weber</u>				14. MOTHER'S MAIDEN NAME <u>Louise Schilling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>			16. SOCIAL SECURITY NO. <u>488-03-4832</u>		17. INFORMANT Address <u>Wife - Mary Helen Weber, as above</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MENINGIOMA OF BRAIN (MALIGNANT)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 MOS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(n) <u>193x</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY. Hour. Month. Day. Year. a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>MARCH 25, 1957</u> to <u>APRIL 17, 1957</u> and last saw her alive on <u>APR. 17, 1957</u> Death occurred at <u>4:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) <u>C. Venillian, M.D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>4/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 19, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beachwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mounds, Ill.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Parber-Aldrich Webster Groves, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>APR 18 '57</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>msb.</u>		

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 *Leslie Welch*.....

Licensed Embalmer No. *439*

P. O. Address *Webster Street*

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.