

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34291

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8379**

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony		Length of stay in 1b 5 days	d. STREET ADDRESS 3200 Taft Av		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frances Middle M. Last WECKBACK			4. DATE OF DEATH Month Sept Day 4 Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 11, 1886	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Anton Blumenkemper			14. MOTHER'S MAIDEN NAME Anna —		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Wm. Weckback 3200 Taft		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic heart disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) with myocardial damage DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 260x					INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 yrs.
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 <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 8:30 Jan-53 to Sept 4-'57 and last saw her alive on Sept 4-'57 . Death occurred at 8:30 p. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE. George A. O'Sullivan, M.D. (Degree or title)			22b. ADDRESS. 7629 Ivoryave		22c. DATE SIGNED 9-6-57
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>	23b. DATE 9-7-57	23c. NAME OF CEMETERY OR CREMATORY Resurrection	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR Fendler Und. Co., 7420 Michigan		25. DATE RECD. BY LOCAL REG. SEP 6 57	26. REGISTRAR'S SIGNATURE Carl Smith Mo		

Dr. O. Sullivan
7629 Swaney
AL2-1242.

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 *W. G. Peterson*

Licensed Embalmer No. *37*

P. O. Address *7420 Y*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.