

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011740

FILED APR 6 1959

Registration District No. 317 Primary Registration District No. 547 STATE FILE NUMBER 737 Registrar's No.

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, give TOWNSHIP only) OR TOWN ST. LOUIS RICH. HTS.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. MARY'S HOSPITAL		d. STREET ADDRESS (If outside, give location) 4160 MARYLAND AVE.	
Length of stay in 1b 45 YEARS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First SUSAN Middle R. Last WEBER			4. DATE OF DEATH Month MARCH Day 17 Year 1959		
--	--	--	---	--	--

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 MARCH 31, 1887	9. AGE (In years last birthday) 71 yrs.	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) ROOMING HOUSE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MT. OLIVE, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	--	---

13a. FATHER'S NAME JACKSON WHEELER	13b. MOTHER'S MAIDEN NAME KATHERINE CRITES	14. NAME OF HUSBAND OR WIFE CHARLES H. WEBER
--	--	--

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.	17. INFORMANT MRS. ANNA OLSON	Address HILLSBORO, ILLINOIS
--	-------------------------	---	---------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bacterial Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Acute Pericarditis		24 hrs
	DUE TO (c) arteriosclerosis		450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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 Death occurred at 2/8/59 to 2/18/59 and last saw her alive on 2/18/59 Death occurred at 5:30 pm on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE John Wheeler M.D. (Degree or title)	22b. ADDRESS 4160 Maryland Ave	22c. DATE SIGNED 2/17/59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MARCH 20, 1959	23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY	23d. LOCATION (City, town, or county) (State) LITCHFIELD, ILLINOIS
---	------------------------------------	---	--

24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE	25. DATE RECD. BY LOCAL REG. 3-19-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
---	--	--

MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 All diseases in Part I must be causally related.

APR 6 1959

11 AM / PM
THUR

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. 4530
P. O. Address St. Louis, Mo

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.