

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 46 2 0 3

FILED *VS* JAN 15 1960 317

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3451

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b		c. CITY OR TOWN <u>ST. LOUIS</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>ST. LOUIS COUNTY Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4956 POTOMAC</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>RUDOLPH</u> Middle <u>WEINBERGER</u> Last				4. DATE OF DEATH Month <u>DEC.</u> Day <u>24</u> Year <u>1959</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>ARCHITECT</u>			11. BIRTHPLACE (City and state or country) <u>CZECHOSLOVAKIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>LOUIS WEINBERGER</u>				13b. MOTHER'S MAIDEN NAME <u>UNKNOWN JOSEPHINE WEINBERGER</u>				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) <u>No</u>				16. SOCIAL SECURITY NO. <u>490-20-6697</u>		17. INFORMANT <u>RUTH WEINBERGER, KIRKWOOD Mo.</u> Address					
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>Multiple skull fractures and brain damage</u> DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Passenger in car involved in 3 car collision</u>							
20c. TIME OF INJURY Hour <u>6:35</u> Minute <u>35</u> p.m. Month <u>12</u> Day <u>24</u> Year <u>59</u>				20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway</u>				20f. CITY, TOWN, OR LOCATION <u>Rural St. Louis Missouri</u>							
21. I attended the deceased from <u>3 C</u> , to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Raymond L. Hand</u> Coroner						22b. ADDRESS <u>Clayton, Mo.</u>			22c. DATE SIGNED <u>1/7/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				23b. DATE <u>DEC. 28 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DAK GROVE MAUSOLEUM</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>			
24. FUNERAL DIRECTOR <u>Thomas Lute 2906 Prairie</u>				25. DATE RECD. BY LOCAL REG. <u>12-25-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *James C. Hill*

Licensed Embalmer No. 4347

P. O. Address 2906

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.