

FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021670

FILED VS JUN 8 1960

318

1003

5184
5184

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP, only) OR TOWN St. Louis		c. CITY OR TOWN Normandy	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 5305 Englewood	
3. NAME OF DECEASED (Type or print) First Middle Last JENNIE DAISY WEBER		4. DATE OF DEATH Month Day Year May 17th, 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-13-99
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil Service		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	11. BIRTHPLACE (City and state or country) DuQuoin, Illinois
13a. FATHER'S NAME David W. Kennedy		13b. MOTHER'S MAIDEN NAME Jane Glover	14. NAME OF HUSBAND OR WIFE Herman Weber
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 495-16-8384	17. INFORMANT'S ADDRESS Jane Weber, 5305 Englewood
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General abdominal Carcinomatosis			INTERVAL BETWEEN ONSET AND DEATH - 1 yr
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, SUICIDE, HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m.	Month, Day, Year		
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 Sept 30, 1947 to May 17, 1960 and last saw her alive on May 16, 1960 Death occurred at 6:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John G. McJannet M.D.		22b. ADDRESS 5014 Thekla Dr	22c. DATE SIGNED 5/17/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-20-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
27. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, St. Louis, 15, Missouri		25. DATE RECD. BY LOCAL REG. MAY 17 1960	26. REGISTRAR'S SIGNATURE Lead Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

77

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ralph C. Linders

Licensed Embalmer No. 4275

P. O. Address St. Louis

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