

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 2 1960 **318**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

Registrar's No. **8328**

-60-033044

STATE FILE NUMBER

|   |  |   |   |  |  |  |  |
|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>   |  |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>St. Louis</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)<br><b>6403 Bishop Pl.</b>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FRED</b> Middle <b>H. DAVIS-WEIDMAN</b> Last <b>SR.</b>   |  |   |   | 4. DATE OF DEATH <b>August 21- 1960</b><br>Month Day Year  |  |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-17-1896</b>                                     | 9. AGE (last birthday)<br><b>63</b>  | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Structural Engineer-Stupp Bros.</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><b>Harrisburg, Penn.</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                               |
| 13a. FATHER'S NAME<br><b>Jacob Weidman</b>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Stock</b>                            |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Mary Weidman</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>408-01-5626</b>                             |  | 17. INFORMANT Address<br><b>Mary Weidman 6403 Bishop Pl.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b><br>DUE TO (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>420.1</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b>                          |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour a.m. p.m.<br>Month, Day, Year   |  |   |   |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>8-15-60</b> to <b>8-21-60</b> and last saw her alive on <b>8-21-60</b><br>Death occurred at <b>8:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |   |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>R. F. Huck MD</b>  |  |   |   | 22b. ADDRESS<br><b>9216 Clayton Rd</b>   |  | 22c. DATE SIGNED<br><b>Aug 23, 1960</b>              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Aug. 25, 1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Missouri Crematory</b>           |  | 23d. LOCATION (City, town, or county)<br><b>St. Louis, Mo.</b>   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser 4228 S. Kingshighway Blvd.</b>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 24 1960</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Loan Smith, M.D.</b> |  |

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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R. W. Stovessand

Licensed Embalmer No. 4007

P. O. Address St. Louis

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.