

NEG 13 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39670
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **531**
(b) Township Primary Registration District No. **1003**
(c) City **ST. LOUIS** (d) Street No. **ST. ANTHONY HOSPITAL** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred **0** yrs. **0** mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **MARION LUCILLE PROBST**

(a) Residence, No. St. **WA OVERLAND, MO.**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city of town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **FEMALE** 4. COLOR OR RACE **WHITE** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **SINGLE**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **MAY 28-1926**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11 5 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **SCHOOL GIRL**
9. Industry or business in which work was done, as saw mill, bank, etc. **RITEXOUR**
10. Date deceased last worked at this occupation (month and year) **November 1927** 11. Total time (years) spent in this occupation **5 YRS**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **OVERLAND, MO.**

FATHER 13. NAME **OTTO A. PROBST**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ST. LOUIS, MO.**

MOTHER 15. MAIDEN NAME **LILLY J. SCHNIPPER**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ST. LOUIS, MO.**

17. INFORMANT (ADDRESS) **OTTO A. PROBST**
2721- PASTEUR-OVERLAND, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE **Memorial Park** DATE **11-19-1937**

19. FUNERAL DIRECTOR (ADDRESS) **Quinn's Bros. Inc.**
2505-1/2-1/2-Overland, Mo.

20. FILE NO. **1107-1-1001** **H. Brecker**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov. 16 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Nov. 15**, 19**37**, to **Nov. 16**, 19**37**
I last saw him alive on **Nov. 15**, 19**37** Death is said to have occurred on the date stated above, at **9:00 A.M.**
The principal cause of death and related causes of importance were as follows:

Bacterial Peritonitis and Septicemia

Date of onset **11/1/37**

Other contributory causes of importance:
Acute Bacteremia perforated Appendix

Name of operation **Appendectomy** Date of **11/16/37**
What test confirmed diagnosis? **Cell. Evid.** Was there an autopsy? **No.**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No.**
If so, specify
(Signed) **A. L. Gold**, M. D.
(Address) **3606 Biavore**

N. B.—Every item of information should be carefully supplied. Accuracy should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, Earl A. Helms Licensed Embalmer No. 3501

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

me L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed Earl A. Helms

Licensed Embalmer No. 3501

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.)