

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9394**  
Registrar's No. **2877**

**791**

**1003**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Jewish Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 days**  
In this community **47 years**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County \_\_\_\_\_  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **5508 Genevieve Ave.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3-** day **26**  
year **40** hour **5** minute **4** A.M.  
21. I hereby certify that I attended the deceased from **3-18**  
19**40**, to **3-26**, 19**40**;  
that I last saw her alive on **3-26**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Carcinoma of Trachea**

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy **Carcinoma of Trachea**

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **E. G. Berger** (M. D. or other) \_\_\_\_\_  
Address **216 S. Kingshighway** Date signed **3-26-40**

3. (a) PRINT FULL NAME **Ruth Frances Ebert**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **05-5167**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **Nil** 6. (c) Age of husband or wife if alive **Nil** years

7. Birth date of deceased **Sept. 2 1892**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**47** **6** **24** hr. min.

9. Birthplace **St. Louis Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Stenographer**

11. Industry or business **Columbia Quarry Co.**

12. Name **Robert Ebert**

13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Augusta Dbelitch**

15. Birthplace **Waterloo, Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Albina Ebert**

(b) Address **Se. May, Mo.**

17. (a) **Burial** (b) Date thereof **3/28/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Zion Cemetery**

18. (a) Signature of funeral director **Edward J. ...**

(b) Address **3934 W. 20th St.**

19. (a) **MAR 28 1940** (b) **J. B. ...**  
(Date received local registrar) (Signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Alfred J. Bodet*

Licensed Embalmer No. 2663

P. O. Address 4204 Prairie Ave

**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 this body is not embalmed, above space should be left blank.**

The first numbers of the Social Security number is missing, will you please send the correct number at once please?

CE 2672

Please write requested information directly on face of supplemental and return in the enclosed franked envelope that requires no postage.

*M.A. 0293*  
*Harry F. Parker*

Harry F. Parker, M. D.  
Special Agent, Bureau of the Census

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Registration District No. ....

Primary Registration District No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ruth F. Ebert

3. (b) If veteran, name war 494  
(c) Social Security No. MO-5167

4. Sex 7 5. Color or race W  
6. (a) Single, widowed, married, divorced D-  
6. (b) Name of husband or wife  
6. (c) Age of husband, or wife, if alive, year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4-29-40 (Date received by registrar) (b) J. H. Brudeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years

20. DATE OF DEATH Month Mar day 26 year 40  
hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h. alive on and that death occurred on the date and hour stated above.  
Immediate cause of death

Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? (Specify type of place) (c) Means of injury

23. Signature (M. D. or other) Address Date signed

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

1940

S-9394

6715

05

494