

FILED JUL 31 1943 318

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6509**

1. PLACE OF DEATH:

(a) County **St. Louis, Missouri**  
(b) City or town **St. Louis, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis City Hospital #1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Bernard J. Robben**

3. (b) If veteran, name war **None** 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased **October 2 1894**  
(Month) (Day) (Year)

8. AGE: Years **48** Months **9** Days **18** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Baker**

11. Industry or business **Bakery**

12. Name **Joseph Robben**

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

14. Maiden name **Elizabeth Thien**

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

16. (a) Informant **Virginia Groll**  
(b) Address **2833 Wyoming Street.,**

17. (a) **Burial** (b) Date thereof **7/23/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **SS Peter & Paul Cemetery**

18. (a) Signature of funeral director **Wingbermuehle Funeral Home**

(b) Address **3819 South Grand Blvd.,**

19. (a) **J. B. Brueck**  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")  
(d) Street No. **920 Chestnut Street.,** (If rural, give location)  
(e) Citizen of foreign country? **No attending Physician** (Yes or No)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27** year **1943** hour **1:25** minute **0** M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

**Heart Stroke**

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) (e) Means of injury \_\_\_\_\_

Signature **Thomas P. Callahan** (M. D. or other) \_\_\_\_\_

Address **Deputy Coroner** Date signed **7-26-43**

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

85

000  
1725  
925

No attending Physician

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed *Albert G. Hoffa*.....

Licensed Embalmer No. *2971*.....

P. O. Address.....

**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, fact should be so stated above.**