

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED SEP 7 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25595**  
Registrar's No. **7372**

Registration District No. **318**

Primary Registration District No. **1003**

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 5567 Pershing  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 066  
(c) City or town St. Louis 1717  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5567 Pershing 917  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Julia Ebert

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

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

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

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Sam Ebert  
13. Birthplace Germany (City, town, or county) (State or foreign country)  
14. Maiden name Lena Goldstein  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Bertha Ebert

(b) Address 5567 Pershing

17. (a) Burial (b) Date thereof 8-24-45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cem.

18. (a) Signature of funeral director H. Rindskopf

(b) Address 5216 Belmont

19. (a) AUG 24 1945 (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22 year 1945 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Aug 20 1945, to Aug 22 1945.

that I last saw her alive on Aug 22 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Neuronal hemorrhage  
arterio sclerosis  
general

Duration 2 day  
years

Due to \_\_\_\_\_  
Due to 83-1

Other conditions Paralysis agitans 4 yrs.  
(Include pregnancy within 3 months of death)

PHYSICIAN

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

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 H. Rindskopf M. Meyer (M. D. or other) M.D.  
Address 568 N. Grand Date signed 8/24/45

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*W. E. Burgess*

Licensed Embalmer No.....

4029

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.**