

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED 2184 1946
Registration District No.

Primary Registration District No. **1003**

State File No. _____
Registrar's No. **7988**

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:
Park Lane Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis** **17**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5067 Kensington Ave.** **129**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No) **0**
 If yes, name country _____

3. (a) PRINT FULL NAME **Habeeb T. Saliba**
3. (b) If veteran, name war **Nil** **3. (c) Social Security No.** **None**

4. Sex **Male** **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 **August 16 1882**
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	0	26	_____ hr. _____ min.

9. Birthplace **Lebanon Syria**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Chemist**

11. Industry or business _____
12. Name **Pannoos Elias Saliba**
13. Birthplace **Unknown Syria**
 (City, town, or county) (State or foreign country)
14. Maiden name **Mary N. Hareek**
15. Birthplace **Unknown Syria**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Adele S. Jones**
(b) Address **5067 Kensington**
17. (a) Burial **(b) Date thereof 9-16-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) 4700 Washington Blvd.
19. (a) SEP 16 1946 **(b) [Signature]**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **18**
 year **1946** hour **9** minute **50 P.M.**
21. I hereby certify that I attended the deceased from **7/18/46**
 19____ to **9/12/46** 19____
 that I last saw him alive on **9:30 pm 9/12/46**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration **9 Mo**
Coronary Sclerosis
 Due to **General Arterio Sclerosis**

Due to _____
 Other conditions **Myocardial Degeneration**
 (Include pregnancy within 3 months of death)
Peptic Ulcers
 Major findings: _____
 Of operations: _____
 Of autopsy **as above**
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 **G. William Pohl, M.D.** (M. D. or other)
Address **5101 Delmar Rd** **Date signed** **9/13/46**

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 John A. Agonowski
Licensed Embalmer No. 3398
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.