

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20730
5333

| | | | | | | | | | |
|--|--|--|---|---|---|---|--|----------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri | | | | b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis | | c. LENGTH OF STAY (in this place) 8 days | | c. CITY (If outside corporate limits, write RURAL and give township) Bürke City, Mo. | | d. STREET ADDRESS (If rural, give location) W R - Vierling Drive | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital | | | | 3. NAME OF DECEASED (Type or Print) a. (First) Theresa | | | | b. (Middle) Anna | |
| | | | | c. (Last) Babst | | 4. DATE OF DEATH (Month) (Day) (Year) 6/24/49 | | | |
| 5. SEX F | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH Apr. 5, 1885 | | | |
| | | | | 9. AGE (In years last birthday) 64 | | IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) 2 19 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | | 11. BIRTHPLACE (State or foreign country) St. Louis, Mo. | | | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13a. FATHER'S NAME Christian Keller | | | 13b. MOTHER'S MAIDEN NAME Anna Vögel sang | | | 14. NAME OF HUSBAND OR WIFE John H. Babst | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS John H. Babst, Jennings, Mo. | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cornary Occlusion | | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ovarian Cyst on Twisted Pedicle | | | | | | | |
| | | DUE TO (c) Diabetes Mellitus | | | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Retrocecal Appendicitis Ch. Cardio-Vascular Renal Disease | | | | | | | |
| 19a. DATE OF OPERATION 6/22/49 | | 19b. MAJOR FINDINGS OF OPERATION Ovarian cyst twisted Pedicle and Endometrial Polyps. | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT SUICIDE HOMICIDE _____ (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 56 (STATE) _____ | | | | | |
| 21d. TIME OF INJURY _____ (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 2nd 6X | | | | | |
| 22. I hereby certify that I attended the deceased from 6/20/49, 19 , to 6/24/49, 19 , that I last saw the deceased alive on 6/24/49, 19 , and that death occurred 10:55 P.m. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) W. H. Stein M.D. | | | | 23b. ADDRESS 6917 W. Florissant | | 23c. DATE SIGNED 6/27/49 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 6/28/49 | | 24c. NAME OF CEMETERY OR CREMATORY St. Ferdinand Cem. | | 24d. LOCATION (City, town, or county) (State) Florissant, Mo. | | | |
| DATE REC'D BY LOCAL REG. JUN 27 1949 | | REGISTRAR'S SIGNATURE J. B. Sauter | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS White Funeral Home, Ferguson, Mo | | | | | |

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed L. M. White

Licensed Embalmer No. 3973

P. O. Address Ferguson, Mo.

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.