

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20945
4983
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1218a Tamm	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1218a Tamm			

3. NAME OF DECEASED (Type or Print) a. (First) Peter b. (Middle) c. (Last) Delarber			4. DATE OF DEATH (Month) (Day) (Year) June 6, 1949			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Oct 21, 1864	9. AGE (In year) (Month) (Day) (Year) 84	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY boilerworker		11. BIRTHPLACE (State or foreign country) St Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME Peter Delarber	13b. MOTHER'S MAIDEN NAME Barbara Schwarz	14. NAME OF HUSBAND OR WIFE
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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. NO.	17. INFORMANT'S SIGNATURE OR NAME Adel Allen	ADDRESS 1218a Tamm
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH indefinite
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary Artery Disease</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (STATE) St Louis Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 5810

22. I hereby certify that I attended the deceased from Jan 26, 1949, to 6-7-49, 19____, that I last saw the deceased alive on 6-4, 1949, and that death occurred at 12:33/4 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Clarence G. Denton</i>	23b. ADDRESS A 27 - Union	23c. DATE SIGNED 6-8-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 6/9/49	24c. NAME OF CEMETERY OR CREMATORY Mt Olive Cemetery	24d. LOCATION (City, town, or county) (State) St Louis, Mo.
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DATE REC'D BY LOCAL REG. JUN 8 1949	REGISTRAR'S SIGNATURE <i>J B Lavater</i>	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 Gravois
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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.....

.....
working under my personal supervision.

Student Embalmer No.

Student
Student Embalmer

Signed

Francis J. Dwyer

Licensed Embalmer No. *2245-*

P. O. Address *St. Louis, 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.