

No. 300
10.48

FILED DEC 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File # **43298**
Registrar's No. **04768**

317

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. **6076**

96
b
D
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Louis		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 township) OR TOWN Jennings		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stx Jennings	
c. LENGTH OF STAY (in this place)		96	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5646 Helen		d. STREET ADDRESS (If rural, give location) 5646 Helen	

3. NAME OF DECEASED (Type or Print) a. (First) HILDA	b. (Middle) C.	c. (Last) RYBAK	4. DATE OF DEATH (Month) (Day) (Year) December 23, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH January 10, 1906	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months 43	IF UNDER 24 HRS. Hours 43 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Herman Kollenberg	13b. MOTHER'S MAIDEN NAME Johanna Jasper	14. NAME OF HUSBAND OR WIFE John J. Rybak, deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME Miss Aurelia Kollenberg	ADDRESS 5646 Helen
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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 1 d.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		2 yr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) chronic myocarditis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			4201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	420.1	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May, 1949, to 12-23, 1949, that I last saw the deceased alive on 12-23, 1949, and that death occurred at 2:35A m., from the causes and on the date stated above.

23a. SIGNATURE Joseph B. Succione M.D. (Degree or title)	23b. ADDRESS 2801 N. Taylor Ave.,	23c. DATE SIGNED 12-23-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-27-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. 12-23-49	REGISTRAR'S SIGNATURE Berbert R. Wombe, M.A.	25. FUNERAL DIRECTOR'S SIGNATURE W. A. Stock Mortuary	ADDRESS 2117 E. Grand
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Dr. Luccione
2801 N. 3rd St

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.

Signed Frank A. Moore

Signed _____
Student Embalmer

Licensed Embalmer No. 3041

P. O. Address 2117 E. 1st

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.