

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25685

FILED AUG 5 1950

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>1750</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Koch (rural)</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> <u>2159</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3660 Montana</u> <u>1</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>George</u>		b. (Middle) <u>-</u>		c. (Last) <u>Terbeck</u>	
4. DATE OF DEATH		(Month) <u>July</u> (Day) <u>20</u> (Year) <u>1950</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>2-24-83</u>		9. AGE (In years last birthday) <u>67</u>		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) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Christian Terbeck</u>		13b. MOTHER'S MAIDEN NAME <u>Frieda Cornelius</u>		14. NAME OF HUSBAND OR WIFE <u>Augusta Stein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, specify or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>??</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hospital Records, Robt. Koch Hosp.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Tuberculosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>002X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs. (?)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) (STATE) <u>002X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-11-47</u> , 19 <u> </u> , to <u>7-20-50</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7-20-50</u> , 19 <u> </u> , and that death occurred at <u>4:20A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>William A. Osmer</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Robt. Koch Hosp</u>		23c. DATE SIGNED <u>7/20/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-22-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>7-20-50</u>		REGISTRAR'S SIGNATURE <u>Robert P. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Halaske 3634 ...</u>			

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 _____

Frank J. Deland

Licensed Embalmer No. _____

2675

P. O. Address _____

N. Levine

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.