

FILED MAY 24 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18970

BIRTH NO. REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4465 Registrar's No. 2225

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Hill</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Hill</b>	
c. LENGTH OF STAY (In this place) <b>6 weeks</b>		d. STREET ADDRESS (If rural, give location) <b>9803 Manchester Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Rock Hill Rest Home</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Ida</b>	b. (Middle) <b>Eva</b>	c. (Last) <b>Starkes</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 18, 1951</b>
-------------------------------------	-----------------------	------------------------	--------------------------	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>February 26, 1869</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
----------------------	-------------------------------	---	---	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New Columbia, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	-----------------------------------	---	---

13a. FATHER'S NAME <b>Alviro A. Austin</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>	14. NAME OF HUSBAND OR WIFE <b>Washington C. Starkes</b>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Austin Onyx Starkes</b>	ADDRESS <b>3639 Hartford St.</b>
--	-------------------------	--	----------------------------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>chronic myocarditis</b>		
	ANTECEDENT CAUSES Morbid 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>422.2</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
--	--	---

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 **April 7, 1951**, to **May 11, 1951**, that I last saw the deceased alive on **May 11, 1951**, and that death occurred at **9:25 P.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>G. T. Weikert M.D.</b> (Degree or title)	23b. ADDRESS <b>3707 Parkway</b>	23c. DATE SIGNED <b>5-19-51</b>
--	----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>May 22, 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Beech Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>North Cairo, Illinois</b>
--	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>5-21-51</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Lomke M.D.</b>	FUNERAL DIRECTOR'S SIGNATURE <b>John H. Gebken Sons</b>	ADDRESS <b>2630 Gravois Ave.</b>
---	--	---	----------------------------------

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

1001  
4

**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 Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

**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.