

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28772
Registrar's No. 7235

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 Missouri 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	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4646 Dahlia		d. STREET ADDRESS (If rural, give location) 4646 Dahlia	
3. NAME OF DECEASED (Type or Print) Louise Marie Tabbert			4. DATE OF DEATH (Month) (Day) (Year) August 11 1951
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, OR FORCED married	8. DATE OF BIRTH 6/4/1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) New York City N Y /		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Schading		13b. MOTHER'S MAIDEN NAME Bernays	
14. NAME OF HUSBAND OR WIFE Otto F		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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Otto F Tabbert 4646 Dahlia	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Hypertensive Heart</i> INTERVAL BETWEEN ONSET AND DEATH 19 yrs. ANTECEDENT CAUSES DUE TO (b) <i>None</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Osteo arthritis</i> 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"/>			
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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>H43X</i>	
22. I hereby certify that I attended the deceased from <i>6-13</i> 1951 to <i>8-11</i> 1951, that I last saw the deceased alive on <i>8-11</i> 1951, and that death occurred at <i>7:30 a.m.</i> , from the causes and on the date stated above.			
22a. SIGNATURE (Degree or title) <i>Philip Schick M.D.</i>		23b. ADDRESS <i>1703 S Grand</i>	
23c. DATE SIGNED <i>8-13-51</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	24b. DATE <i>8/14/51</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Park Lawn Cem</i>	24d. LOCATION (City, town, or county) (State) <i>St Louis County Mo</i>
DATE REC'D BY LOCAL REG. <i>AGG 14 1951</i>	REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J L Ziegenhein & Sons 7027 Gravois</i>	

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.....

Signed.....

W. G. Peterson

Signed.....

Student Embalmer

Licensed Embalmer No. *3767*

P. O. Address *7027 Graves's*

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.