

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43448**

FILED JAN 10 1952

1003

Registrar's No. **11157**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>	PRIMARY REG. DIST. NO. _____	State File No. <b>43448</b>
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>210</b>		
b. CITY (If outside corporate limits, write RURAL and give townshp) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give townshp) <b>St. Louis</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4234 Lexington Ave.</b>		e. STREET ADDRESS (If rural, give location) <b>4234 Lexington Ave.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>John (Jack)</b>		b. (Middle) _____		c. (Last) <b>Wobbe</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 17, 1951</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 27, 1879</b>	9. AGE (In years last birthday) <b>72</b> 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) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Schruggs</b>		11. BIRTHPLACE (State or foreign country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13a. FATHER'S NAME <b>William Wobbe</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Reardon</b>		14. NAME OF HUSBAND OR WIFE <b>Roxie Wobbe</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NUMBER <b>494-07-9558</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Roxie Wobbe, 4234 Lexington Ave.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis. Hypertension.</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Anemia</b>		INTERVAL BETWEEN ONSET AND DEATH _____
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) _____
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? <b>321X</b>
22. I hereby certify that I attended the deceased from <b>myself</b> <b>1946</b> , to <b>12-16</b> , 1951, that I last saw the deceased alive on <b>12-16</b> , 1951, and that death occurred at <b>8:30A</b> <b>am.</b> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Garin D. Bernwald M.D.</b>		23b. ADDRESS <b>3409 N. Union</b>		23c. DATE SIGNED <b>12-17-51</b>
24a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12/20/51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>				
DATE REC'D BY LOCAL REG. <b>DEC 17 1951</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>PROVOST UND. CO., 3710 N. Grand Blvd.</b>

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

*Stanley H. Dixon*

Licensed Embalmer No.

*4193*

P. O. Address

*St. Louis*

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.