

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45061

State File No. _____

FILED JAN 26 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **12051**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. Louis		c. CITY (If outside corporate limits, write RURAL and give township) ST. Louis 2179	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 3219 EADS AV.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3219 EADS AV.			

3. NAME OF DECEASED (Type or Print) a. (First) NORMAN b. (Middle) RYBITZKI c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Dec 29 - 52		
5. SEX M.		6. COLOR OR RACE W		7. MARRIED - NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	
8. DATE OF BIRTH JAN-7-1869		9. AGE (In years last birthday) 83 YRS		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSULTING		10b. KIND OF BUSINESS OR INDUSTRY ENGINEER		11. BIRTHPLACE (City and State or Foreign Country) ST. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME RYBITZKI		13b. MOTHER'S MAIDEN NAME CAROLINE BOSSO		14. NAME OF HUSBAND OR WIFE KATHERINE RYBITZKI	
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 ADDRESS Jessie Calicote 8219 Eads Av	

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		INTERVAL BETWEEN ONSET AND DEATH 5 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Visceral Carcinoma		
	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		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1999	

22. I hereby certify that I attended the deceased from **Oct 23, 1952** to **Dec 28, 1952**, that I last saw the deceased alive on **Dec 28, 1952**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE J. H. French M.D. (Degree or title)		23b. ADDRESS 1457 So. Campbell St. St. Louis Mo		23c. DATE SIGNED Dec 20, 52	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE Dec 31-52		24c. NAME OF CEMETERY OR CREMATORY VALHALLA Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo					

DATE REC'D BY LOCAL REG. DEC 30 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schmur 3125 Lafayette Av	
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(Licensed Embalmer's Statement on Reverse Side)

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

John B. Volzmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.