

FILED DEC 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41137**
11375
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE				b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. LENGTH OF STAY (In this place) 25 Days				c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Hospital				d. STREET ADDRESS (If rural, give location) 15 2915 Mt. Pleasant					
3. NAME OF DECEASED (Type or Print)		a. (First) Charles		b. (Middle) J.		c. (Last) Sebold		4. DATE OF DEATH (Month) (Day) (Year) II-30-53	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH July 16 1870		9. AGE (In years last birthday) 83 If UNDER 1 YEAR: Months Days If UNDER 12 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Zaharisis Sebold			13b. MOTHER'S MAIDEN NAME Not Known			14. NAME OF HUSBAND OR WIFE Henrietta (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No			16. SOCIAL SECURITY 495-14-8912		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Fank 4535 Minnesota				
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia RESIDENT CAUSES (b) Pyelonephritis DUE TO (b) Arterio-Sclerosis DUE TO (c) Fracture L4-5 LUMBAR VERTEBRÆ 2. OTHER SIGNIFICANT CONDITIONS (d) Fracture L4-5 LUMBAR VERTEBRÆ						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
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) 600.0 F					
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?					
22. I hereby certify that I attended the deceased from Nov 2, 1953 to Nov 30, 1953 , that I last saw the deceased alive on Nov 29, 1953 , and that death occurred at 8:35 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE L. Resnikoff				(Degree or title) MD		23b. ADDRESS 3612 S. Jefferson		23c. DATE SIGNED Nov 30, 1953	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/2/53		24c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. DEC 1 1953		REGISTRAR'S SIGNATURE Charles Smith MD			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Schumacher 3013 Meramec				

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 _____

Jack Hainpl

Licensed Embalmer No. *4746*

P. O. Address *St Louis Mo*

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.