

FILED AUG 4 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

23673

6229

318

1003

Registrar's No.

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis County, Mo. 14	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		STREET ADDRESS (If rural, give location) 1608 North Warson Road	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) SUE	b. (Middle) ANN	c. (Last) EBERLE	(Month) 7	(Day) 19	(Year) 55
5. SEX female	6. COLOR OR RACE white	7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH July 12th, 1955.	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 24 HRS. Days	IF UNDER 1 MRS. Hours Min.

13a. FATHER'S NAME Oliver W. Eberle	13b. MOTHER'S MAIDEN NAME Laverne M. Seidmeyer	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Oliver W. Eberle, 1608 North Warson Road

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, ashenia, 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) Spina Bifida + Hydrocephalus		
	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 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)	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 7-12, 1955, to 7-19, 1955, that I last saw the deceased alive on 7-19, 1955, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank J. Robertson, M.D.	23b. ADDRESS 634 N. Grand Ave.	23c. DATE SIGNED 7-19-55
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 7-20-55	24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

DATE REC'D BY LOCAL REG. JUL 19 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.	25. FUNERAL DIRECTOR'S SIGNATURE C. R. Lupton & Sons; 7233 Delmar Blvd.,	ADDRESS
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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.....  
Signature of Student Embalmer

*Max Embalmer*

*C. R. Lupton & Sons*  
Signed *W. C. Ham*

Licensed Embalmer No.....  
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting. -  
If this body is not embalmed, fact should be so stated above.