

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33076

FILED NOV 15 1955

State File No. ....

318

1003

Registrar's No. 9237

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 <b>Missouri</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>1 Day</b>		f. STREET ADDRESS (If rural, give location) <b>14 6347 Bancroft Ave. 21410</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Incarnate Word Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>Bernard</b>		a. (First)	b. (Middle) <b>S.</b>	c. (Last) <b>Post Sr.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>October 20, 1955</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>April 24, 1899</b>	9. AGE (In years last birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wholesale Milk Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>

13a. FATHER'S NAME <b>Bernard S. Post</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Held</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret Post</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 1</b>		16. SOCIAL SECURITY NO. <b>492-07-1985</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Margaret Post 6347 Bancroft 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
		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 <b>420.1</b>		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?	

22. I hereby certify that I attended the deceased from 10-18, 1955, to 10-20, 1955, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 9 P. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Rolph Bergel</b> (Degree or title)		23b. ADDRESS <b>3203 South Grand</b>		23c. DATE SIGNED <b>Oct. 22-1955</b>	
---	--	---	--	---	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/24/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>	
---	--	------------------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. <b>OCT 24 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>	
--	--	---	--	--	--

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10-48

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

Signed *Robert F. Gebken*

Licensed Embalmer No..... 4144

P. O. Address 2630 Gravois A

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.