

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18654**
4610

FILED MAY 27 1957

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 15 Yrs.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor				e. STREET ADDRESS (If rural, give location) 3400 S. Grand Blvd.				
3. NAME OF DECEASED (Type or Print) a. (First) Josephine			b. (Middle) _____		c. (Last) Forst		4. DATE OF DEATH (Month) (Day) (Year) May 14, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH December 15, 1874		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Days 4	IF UNDER 14 HRS. Hour 29 Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Belleville, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Aloys Forst			13b. MOTHER'S MAIDEN NAME Josephine Boul		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister Marie Jean 3400 S. Grand Blvd.				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Dis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.0				INTERVAL BETWEEN ONSET AND DEATH yr yr.		
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) St. Louis, Mo.				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		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 Jan, 1957 , to 3/14/57 , 19____, that I last saw the deceased alive on 3/12/57 , 19____, and that death occurred at 5 P m., from the causes and on the date stated above.								
23a. SIGNATURE [Signature]		(Degree or title) Ind.		23b. ADDRESS 8059 Watson Rd.		23c. DATE SIGNED 5/15/57		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/17/57		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.		
DATE REC'D BY LOCAL REG. MAY 15 '57		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2630 Gravois Ave.		

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

Signed *Robert J. Lybman*.....

Licensed Embalmer No..... 4144

P. O. Address... 2630 Grayois A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.