

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30191
STATE FILE NUMBER

FILED AUG 26 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7413

| | | | | | |
|--|---------------------------|---|--|--|---|
| 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, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital doa | | Length of stay in 1b 2/5 | d. STREET ADDRESS 3541 Bingham | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Herman Wobbe | | | 4. DATE OF DEATH Month Day Year Aug. 5, 1957 | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 7, 1892 | 9. AGE (In years last birthday) 64 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brush Maker | | 10b. KIND OF BUSINESS OR INDUSTRY Bensinger Brush Co. | | 11. BIRTHPLACE (City and state or country) Illinois | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Herman Wobbe | | | 14. MOTHER'S MAIDEN NAME Susan Altgilbers | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Mrs. Bernice Kracke 4140 Davis | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. DUE TO (b) Coronary Insufficiency DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 14 wks. |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from June 4th, '56, to August 5th, '57 and last saw her alive on Aug 3rd, & 57 Death occurred at 1030 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) W. M. Gausman, M.D. | | | 22b. ADDRESS 6376 Clayton Rd., St. L. | | 22c. DATE SIGNED 8/6/57 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 8-9-57 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection | | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo. | | | 25. DATE RECD. BY LOCAL REG. AUG 8 57 | | 26. REGISTRAR'S SIGNATURE K. Carl Smith M.D. |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

3

City

DR. WILBERT GANSLOSER
6376 CLAYTON

12³⁰ til 4
times w ep.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *David J. Ford*

Licensed Embalmer No. *4*

P. O. Address *Si J*

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.