

Health, Welfare Public Service
 400
 300
 1-56
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. All
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-012725

STATE FILE NUMBER

FILED APR 3 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 844

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>NORMANDY</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Hill Top Nursing Home 3wks</i>		Length of stay in lb <i>3wks</i>	d. STREET ADDRESS (If outside, give location) <i>1417 Salisbury</i>
3. NAME OF DECEASED (Type or print) First <i>Magdalena</i> Middle <i>Ebert</i> Last <i>Ebert</i>		4. DATE OF DEATH Month <i>3</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-14-1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	9. AGE (In years last birthday) <i>76</i>
11. BIRTHPLACE (City and state or country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Michael Weiss</i>		14. MOTHER'S MAIDEN NAME <i>Magdalena</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Anna Thomas - 1417 Salisbury</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Movet + Rectal Hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Dysenteric Ulcer</i> DUE TO (c) <i>5410</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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 <i>p. m.</i> Month, Day, Year			
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 <i>Feb 26</i> to <i>Mar 22</i> and last saw ^{her} him alive on <i>Mar 22</i> Death occurred at <i>T. A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Walter A. Koch M.D.</i>		22b. ADDRESS <i>3901 W. Florissant</i>	22c. DATE SIGNED <i>3/24/58</i>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>3-26-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Edw Koch + Son - 3516 N. 14th</i>	25. DATE RECD. BY LOCAL REG. <i>3-25-58</i>	26. REGISTRAR'S SIGNATURE <i>Nerbert P. Danke M.D.</i>	

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 *Herbert J. Law Jr.*.....

Licensed Embalmer No. *480*

P. O. Address *Hickory St. 2*.....

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.