

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003408

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registration No.

177

300
-57
26
83

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION # 1 Hosp.		d. STREET ADDRESS 3665 Market St.	
Length of stay in lb 49 days		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Rabb Last			4. DATE OF DEATH Month 1 Day 5 Year 59
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1900
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during working life, even if retired) laborer	11. BIRTHPLACE (City and state or country) Nashville, Tenn. /
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Rabb	
13b. MOTHER'S MAIDEN NAME Mattie Hoover		14. NAME OF HUSBAND OR WIFE None	
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.	
17. INFORMANT Hattie Morris-311 A.N. Garrison		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subsidiary Edema Edema of the Brain Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Multiple Fractures of Both Legs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) suffered when struck by car			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY 6:30 p.m. 11/17/58			20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Street
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. CITY, TOWN, OR LOCATION St. Louis Mo
20f. STATE Mo			21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at 445 A m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Joseph M. Quinn		22b. ADDRESS 1300 Clair	
22c. DATE SIGNED 11/17/59		23. NAME OF CEMETERY OR CREMATORY Oakdale	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-12-59	
23c. LOCATION (City, town, or county) St. Louis Mo.		23d. STATE Mo.	
24. FUNERAL DIRECTOR A. L. Beal Und.Co.-4303 Delmar		25. DATE RECD. BY LOCAL REG. JAN 7 '59	
26. REGISTERAR'S SIGNATURE Carl Smith mo mjs			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 (1) Rueland

Licensed Embalmer No. 2921

P. O. Address 621

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.