

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008159

FILED VS FEB 23 1960

2 1511

STATE FILE NUMBER

INDEXED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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		Length of stay in 1b		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 Lutheran Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4522 Loughborough		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES B. EBERT				4. DATE OF DEATH Month Day Year Feb. 8 1960			
5. SEX Female	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 2-11-1880	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME John A. Fischer			13b. MOTHER'S MAIDEN NAME Catherine Haar		14. NAME OF HUSBAND OR WIFE Late William A. Ebert		
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 Address Marion Ebert 4522 Loughborough Av.			
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>Cardiac failure</i> DUE TO (b) <i>chronic myocarditis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture left hip.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>8-10 yrs</i>	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Fell off home 2/1/60.</i>			
20c. TIME OF INJURY Hour Month, Day, Year <i>2 1 60</i>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>02 Home</i>		20f. CITY, TOWN, OR LOCATION <i>St Louis</i>		COUNTY <i>Mo</i>	STATE
21. I attended the deceased from <i>1:52</i> to <i>2/8/60</i> and last saw her alive on <i>2/8/60</i> Death occurred at <i>1:20 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>R. W. Schmaier M.D.</i>				22b. ADDRESS <i>6817 Groves</i>		22c. DATE SIGNED <i>2/9/60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Feb. 11, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>S/S Peter & Paul Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Kriegshauser 4228 S. Kingshighway</i>				25. DATE RECD. BY LOCAL REG. <i>FEB 9 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loal Smith. M.D.</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed

W. L. [Signature]

Licensed Embalmer No. 4533

P. O. Address _____

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