

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

-60-008242

2 1763

STATE FILE NUMBER

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 5413 Quincy St	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WILLIAM Middle F. Last Gebert			4. DATE OF DEATH Month 2 Day 13 Year 1960		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1896	9. AGE (last birthday) 63 Years	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	10b. KIND OF BUSINESS OR INDUSTRY Redeemer Church	11. BIRTHPLACE (City and state or country) Germany	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Frederick Gebert	13b. MOTHER'S MAIDEN NAME ????Maier	14. NAME OF HUSBAND OR WIFE Alma Gebert
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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. 488-09-3717	17. INFORMANT Alma Gebert	Address 5415 Quincy St
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 + 1 1/2 +
IMMEDIATE CAUSE (a) Cancer of Lung (Bronchogenic)		
DUE TO (b) Cancer of Lung		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) 162.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from 2/11/60 to 2/13/60 and last saw her him alive on 2/10/60
Death occurred at 11:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Hubert P Smith M.D.</i>	(Degree or title)	22b. ADDRESS 5203 Chaffee	22c. DATE SIGNED 2/15/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 2-17-1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) 7800 St. Charles Road Mo
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24. FUNERAL DIRECTOR Bigenheim Bros	ADDRESS 3409 Gravois Av	25. DATE RECD. BY LOCAL REG. FEB 15 1960	26. REGISTRAR'S SIGNATURE <i>Hubert P Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m. d. r. s.

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

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 Stanley A. Sica
 Licensed Embalmer No. 4193
 P. O. Address St. J.

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.