

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

2529

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **Deaconess Hospital** St. **73** Ward)

2. FULL NAME

Rebecca Kennard Ober
 (a) Residence. No. **Deaconess Hospital 11** Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William a. Ober**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 11-1851**

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
76 8 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at home**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kentucky**

PARENTS
 10. NAME OF FATHER **J. J. Newman**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**
 12. MAIDEN NAME OF MOTHER **Mary Kennard**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Maryland**

14. INFORMANT **E. B. Shryver**
 (Address) **5831 Clemens av.**

15. FILED **JAN -3 1928** **Max C. Starckoff**
 REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan. 1 1928**

17. I HEREBY CERTIFY, That I attended deceased from **about** **1920** to **Dec. 31 1927**, and that I last saw him alive on **December 31 1927**, and that death occurred, on the date stated above, at **12 12 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio sclerosis
Thrombosis (duration) **many** yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) **hemiplegia - right**
 (duration) **10** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF **-**
 WAS THERE AN AUTOPSY? **No**
 WHAT TEST CONFIRMED DIAGNOSIS? **clinical**
 (Signed) **Wesley Luten**, M. D.
1-2 1928 (Address) **St. Louis, Mo**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bellefontaine** DATE OF BURIAL **Jan 3 1928**
 20. UNDERTAKER **E. C. Lupton** ADDRESS **2449 Olive St.**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

