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.

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

Do not use this space.

23525

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 7040

City St. Louis (No. City Hospital St. ..... Ward)

2. FULL NAME #5165 Sebastian Greber

(a) Residence, No. 1718 O'Fallon St., 25 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thresa Greber

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 24, 1869

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	61	11	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Rubber Day

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 2?1

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

FATHER

13. NAME Unknown Greber

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT (ADDRESS) Hospital Information Gladys Hempel City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary Cemetery DATE 6/27 1931

19. UNDERTAKER (ADDRESS) Arthur J. Donnelly Mult Co 2039 Wash St

20. FILED ..... 19 Max C Staridge Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25, 1931

22. I HEREBY CERTIFY, That I attended deceased from June 25, 1931, to June 25, 1931

I last saw him alive on June 25, 1931. Death is said to have occurred on the date stated above, at 9:30 A.m.

The principal cause of death and related causes of importance were as follows:

Chronic Cardio vascular renal disease

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Other contributory causes of importance:

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Date of onset

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) V E Scherman, M. D.

(Address) City Hospital

Grever