

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41242
10365
Registrar's No. _____

Registration District No. 7000

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: Bethesda Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

8. (a) PRINT FULL NAME Alice Kobush | 2-A
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased 12 28 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 11 4 hr. min.

9. Birthplace New Florence, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

FATHER { 12. Name Frank Bass
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Harriett Oliver
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm. Kobush

(b) Address New Florence, Mo.

17. (a) Removal (b) Date thereof 11/3/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Florence, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) DEC 4 1939 (b) J. F. Brubaker
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town New Florence NR
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 2nd
year 1939 hour 11 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-25, 1939, to 12-2-, 1939
that I last saw her alive on 11-1-, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardites, chronic Duration _____

Due to _____
Due to _____

Other conditions Endometritis
(Include pregnancy within 3 months of death)

Major findings: Endometritis
Of operations _____

Of autopsy Reposed
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (Means of injury)

23. Signature John Stewart (M. D. or other) _____
Address Wesley Date signed 12/2/39

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address.....

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 this body is not embalmed, above space should be left blank.