S. No. 2
—11-10-39
. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9422

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2905

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: De Paul Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Thirty Minn. (Specify whether
In this community 9 MO. And 13 Days. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits write "RURAL") 9
(d) Street No. 4452A Clarence (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Jo Ann Kobusch
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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 15, 1939 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
	9	13	hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Lester Kobusch
13. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Johanna Sheeran
15. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Lester Kobusch
(b) Address 4452A Clarence
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 30, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Stroot Carroll
(b) Address 4600 Natural Bridge
19. (a) MAR 28 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28 year 1940 hour 7 minute 05 A. M.
21. I hereby certify that I attended the deceased from 19, to 19 40 that I last saw him alive on March 28 19 40 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Anaphylactic Reaction to Serum Test Diphtheria
Due to Tox in for Immunization.
Due to
Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Oedema Brain & Lungs. Hemorrhagic spots in lung

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Robert Belsby (M. D. or other)
Address 2729 N. Broadway Date signed 3/28/40

(Licensed Embalmer's Statement on Reverse Side)

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 Grant H Stout

Licensed Embalmer No. 2245

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.

S. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9422-

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2905

1. PLACE OF DEATH:

(a) County .....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
.....
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(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.

3. (a) PRINT FULL NAME Jo Ann Kobusch -

3. (b) If veteran name war ..... 3. (c) Social Security No. .....

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced S -

6. (b) Name of husband or wife ..... 6. (c) Age of husband, or wife, if alive ..... years

7. Birth date of deceased ..... (Month) ..... (Day) ..... (Year)

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

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar, 28-40 day .....
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from .....
..... 19....., to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration
Change made - 5-15-40
by E Rosenthal -

Due to Child did not have

Due to Scarlet fever -

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

Major findings:
Of operations ..... 179 ..
Of autopsy .....

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

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

1940
S-9422