

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34109**
Registrar's No. **8806**

Registration District No. **7911**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **ST Louis's Mo**
(b) City or town **ST Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Dunnicca**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
In this community **Life**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: **Herbel, J. HERBEL**

3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Emma Weiss Herbel** 8. (c) Age of husband or wife if alive **85** years

7. Birth date of deceased **9-2-1956**
(Month) (Day) (Year)

8. AGE: Years **84** Months **1** Days **21** If less than one day hr. min.

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

10. Usual occupation **Retired 33 years**

11. Industry or business **Bond Broker**

12. Name **Abraham Herbel**

13. Birthplace **Wurms, Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Grate**

15. Birthplace **Alton, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs E. Herbel**

(b) Address **3951 Dunnicca**

17. (a) **Cremation** (b) Date thereof **10-26-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Crematory**

18. (a) Signature of funeral director **Southern Funeral Home**

(b) Address **6227 S. Grand**

OCT 25 1940 (Date received local registrar)

(b) **J. Herbel** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **16**
(c) City or town **ST Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3951 Dunnicca St**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **years.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCT** day **23rd**
year **1940** hour **1** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **Oct 23**, 19**40**
that I last saw him alive on **OCT 23**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **2 yrs**

Due to **Arterio Sclerosis**

Due to **Arterio Sclerosis**

Other conditions (Include pregnancy within 3 months of death)

Hypertrophy of Prostate

Major findings: Of operations

Of autopsy

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)

(e) Means of injury **1**

23. Signature **Dr. Urban** (M. D. **1**)

Address **1537 S. Grand St** Date signed **10/23/40**

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 _____

Licensed Embalmer No. _____

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.