

No. 2
4-13-40
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

40229

State File No. _____

10000

JAN 15 1941 791

Registration District No. _____ Primary Registration District No. 1003

Registrar's No. _____

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

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:
St. John's 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____ *NOR*

(c) City or town East St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 717 Bond Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Lybarger

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rula

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Dec. 6 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>11</u>	<u>28</u>	_____ hr. _____ min.

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

10. Usual occupation Watchman

11. Industry or business Coal Co.

12. Name Samuel Lybarger

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

14. Maiden name Lizzie Pratz

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

16. (a) Informant Mrs. Rula Lybarger

(b) Address 717 Bond Ave.

17. (a) Removal (b) Date thereof 12/5/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleville, Ill.

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

(b) Address DEC 5 1940 4700 Washington Ave.

19. (a) DEC 5 1940 (b) J. H. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 4
year 1940 hour 2 p.m. minute _____ M.

21. I hereby certify that I attended the deceased from Nov 29
1940, to Dec 4, 1940
that I last saw him alive on Dec 4, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death:
myocardial infarction 3 days
Cholera-Subacute nephritis 3 days
Tuberculous pneumonia 5 days

Due to _____

Due to non-specific type

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

108

Duration

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) (e) Means of injury _____

23. Signature J. H. Bredeck (M. D. or other) M.D.

Address 490 2 Maryland Date signed 12/5/40

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.....

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, fact should be so stated above.