

FILED JUL 17 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6191

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **One day**
(Specify whether
In this community.....
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")
(d) Street No. **2725 A Armand Pl.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME..... **Mathias Rebb Sr.**

3. (b) If veteran, name war..... **No** 3. (c) Social Security No. **702-12,4664**

4. Sex **Male** 5. Color or race **Wht.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife..... **Christina Rebb** 6. (c) Age of husband or wife if alive **57** years
7. Birth date of deceased **April 29 1880**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 2 5 hr. min.

9. Birthplace..... **Hungaria 4**
(City, town, or county) (State or foreign country)

10. Usual occupation..... **Laborer**
11. Industry or business..... **Rail Road Yards**

MOTHER FATHER { 12. Name..... **Frank Rebb**
13. Birthplace..... **Hungaria 4**
(City, town, or county) (State or foreign country)
14. Maiden name..... **Unknown**
15. Birthplace..... **Unknown 9**
(City, town, or county) (State or foreign country)

16. (a) Informant..... **Christina Rebb**
(b) Address..... **2725 A Armand Pl.**

17. (a) **Burial** (b) Date thereof **7/8/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation..... **Sun Set Park**

18. (a) Signature of funeral director..... **J. S. Maxwell**

(b) Address..... **1926 Allen Ave.**

19. (a) **JUL 8 1943** (b) **J. F. Medsick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **4**
year **1943** hour **11** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **July 21 - 1943**
to **July 4** 19 **43**
that I last saw him alive on **July 4** 19 **43**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Myocarditis Chronic
Auricular Fibrillation

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

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..... **Robert E. Warner M.D.** (M.D. or other)
Address..... **Paul Brown Bldg. St. Louis Mo** Date signed **July 6 43**

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

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

Signed D. M. Davis
Licensed Embalmer No. 3741
P. O. Address 1926 allen ave

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.