

**FILED** OCT 30 1945 **STANDARD CERTIFICATE OF DEATH**  
1003

State File No. 29437  
Registrar's No. 8454

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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:  
2531 Warren St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether

In this community About 25 Years  
years, months or days)

3. (a) PRINT FULL NAME John A Toebe

3. (b) If veteran, name war 1

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 Frances Toebe

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased 8 13 1887  
(Month) (Day) (Year)

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

58	1	15	hr. _____ min.
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9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Light Haying

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Toebe

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

14. Maiden name Margaret Fleichman

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

16. (a) Informant Mrs. Frances Toebe

(b) Address 2531 Warren St.

17. (a) Burial (b) Date thereof 10-1-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S. Peters & Paul

18. (a) Signature of funeral director Joseph H. Bredsch

(b) Address 2228 St. Louis, Ave

19. (a) SEP 30 1945 (b) J. J. Bredsch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis 17 20  
(If outside city or town limits, write "RURAL")

(d) Street No. 2531 Warren St 9  
(If rural, give location)

(e) Citizen of foreign country? NO 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28 th  
year 1945 hour 1:40 minute \_\_\_\_\_ A.M.

21. I hereby certify that I attended the deceased from April 5<sup>th</sup>  
1945 to Sept. 28 1945;  
that I last saw him alive on Sept. 17 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of the myocardium & chronic myocarditis

Due to mitral insufficiency & aortic stenosis

Due to hypertension

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: none

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) no

(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 CS

23. Signature Dr. J. P. Murphy M.D. (M. D. or other) \_\_\_\_\_  
Address 2616 North Washington Date signed 9-28-45

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

00  
17  
9

**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 *Marjorie A. Cashier*  
Licensed Embalmer No. *3949*  
P. O. Address *St. Louis MO*

**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.**