

No. 2
-12-45
5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18888

FILED MAY 29 1947

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4983**

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

1. PLACE OF DEATH:

(a) County St. Louis

(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. Anthony Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 1913 South 11th Street
23
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRANCES GUBSER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16th
year 1947 hour _____ minute 00 A. M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife John Gubser

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

7. Birth date of deceased December 24-1980
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 15, 1947 to May 16, 1947
that I last saw he alive on May 15, 1947
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>4</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death Intestinal Obstruction 5 days
Incarcerated Femoral Hernia 5 days

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

10. Usual occupation Housewife

Other conditions (include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____

11. Industry or business _____

12. Name Joseph Marek

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

14. Maiden name Unknown

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Of autopsy Capit. Intestinal Obstr. + Volvulus of ileum

16. (a) Informant Lillian Bergmann

(b) Address 6222 Nottingham Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

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? _____

18. (a) Signature of funeral director Maxwell

(b) Address 1926 Allen Avenue

19. (a) MAY 17 1947 (Date received local registrar)

(b) J. F. Bredek (Registrar's signature)

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature Ronald Benjamin (M. D. or other) MD

Address 7430 Virginia Ave Date signed 5/16/47

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 Benj. C. Deane
Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.