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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 12 1948

MISSOURI DIVISION OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. **24315**
Registrar's No. **6688**

Registration District No. **318** Primary Registration District No. **100**

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: **Christian Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 1/2 Weeks**
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **MOO**

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

(d) Street No. **4547 Red Bud Ave**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

3: (a) PRINT FULL NAME **Carrie H. Gloor**

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

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

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

7. Birth date of deceased **September 18 1872**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
75	10	10	hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Unknown**

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

14. Maiden name **Elizabeth Arbeller**

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

16. (a) Informant **Albert Wagner**

(b) Address **8755 Partridge Ave**

17. (a) **Cremation** (b) Date thereof **7-31-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Math. Hermann & Son, Inc.**

(b) Address **2161 E. Fair Ave**

19. (a) **JUL 30 1948** (Date received local registrar)
J. Z. Breda (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **28**
year **1948** hour **6** minute **55** P. M.

21. I hereby certify that I attended the deceased from **June 27**, 19**48**, to **July 28**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Thrombus of Cerebral (Posterior) Artery**

Duration **14 days**

Due to _____

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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 _____

Signature **Beane J. Morant** (M. D. or other) **MD**

Address **4032 W. 9th** Date signed **7/28/48**

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.....

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

Signed W. W. Hat

Licensed Embalmer No. 3737

P. O. Address 2161 E. Fair

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.