

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28063

State File No. 7144

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. LENGTH OF STAY (in this place) 1 day		b. COUNTY Missouri	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				d. STREET ADDRESS (If rural, give location) 3116a California			
3. NAME OF DECEASED (Type or Print)		a. (First) LaVerne		b. (Middle) J.		c. (Last) Gabriel	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		4. DATE OF DEATH (Month) (Day) (Year) 8/14/49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		8. DATE OF BIRTH Aug. 18, 1925		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 18 HRS. Hours Min. 23	
13a. FATHER'S NAME James Koch				13b. MOTHER'S MAIDEN NAME Louise Klein		14. NAME OF HUSBAND OR WIFE Charles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 359-16-2752		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles Gabriel--3116a California			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH					
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 316			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 0 800			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:05a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Patricia Taylor, MD				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 8-16-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/17/49		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 16 1949 J. H. Forster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Weldert 3634 Gravois					

(Licensed Embalmer's Statement on Reverse Side).

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Robert C Wheeler .....

Licensed Embalmer No. 2128 .....

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.