

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38676
Registrar's No. 9958

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of Poor 5		d. STREET ADDRESS (If rural, give location) 20 3225 N. Florissant Ave. 19	

3. NAME OF DECEASED (Type or Print) a. (First) John Ebinger b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1949		
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5. SEX M. 10	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S. 11	8. DATE OF BIRTH July 22, 1888	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 3	IF UNDER 1 HR. Days 26	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo. B	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Frederick Ebinger	13b. MOTHER'S MAIDEN NAME Mary O'Toole	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Sister Jeane, 3225 N. Florissant Ave.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cardio-vascular renal disease</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 181a
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4444
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22. I hereby certify that I attended the deceased from Oct 12, 1949, to Nov 18, 1949, that I last saw the deceased alive on Nov 17, 1949, and that death occurred at 7 a. m., from the causes and on the date stated above.

23a. SIGNATURE <i>Edward H. Holte MD</i>	23b. ADDRESS 2435 N Grand Blvd	23c. DATE SIGNED 11-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 19, 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. NOV 19 1949	REGISTRAR'S SIGNATURE <i>J. Blaser</i>	FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>	ADDRESS 3840 Lindell Blvd.
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(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.....

W. Van Matre

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.