

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39471

State File No. 10115

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		d. STREET ADDRESS (If rural, give location) 22-1112 S. 9th St, '0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1112 S. 9TH ST.				d. STREET ADDRESS (If rural, give location) 22-1112 S. 9th St, '0			
3. NAME OF DECEASED (Type or Print) a. (First) ROSINA		b. (Middle)		c. (Last) YEREB		4. DATE OF DEATH (Month) (Day) (Year) NOV. 23 1949	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH MARCH 11, 1861	
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months 8		IF UNDER 1 YEAR Days 12		IF UNDER 1 HR. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME JOSEPH WALSTINER		13b. MOTHER'S MAIDEN NAME GARABOL		14. NAME OF HUSBAND OR WIFE ANTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANNA MARTY 1112 S. 9th			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Debility				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 9th		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 11782					
22. I hereby certify that I attended the deceased from 10-28-1949, to 11-22-1949, that I last saw the deceased alive on 10-28-1949, and that death occurred at 6 a. m., from the causes and on the date stated above.							
23a. SIGNATURE C. F. Kraepel M.D.				23b. ADDRESS 905 Morrison Ave		23c. DATE SIGNED 11-23-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE Nov. 25, 1949		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. NOV 25 1949		REGISTRAR'S SIGNATURE J. B. Casales		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons		ADDRESS 2630 Gravois Ave	

WRITE PLAINLY—USING UNFAADING 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 F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

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.