.S. No. 300
EV. 10-48

FILED APR 10 1950
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10457

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2997

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: 2234
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
d. STREET ADDRESS (If rural, give location): 23-1710 S. 7th ST.

3. NAME OF DECEASED (Type or Print)
a. (First): MAMIE
b. (Middle):
c. (Last): GARBS

4. DATE OF DEATH (Month) (Day) (Year): March 28th, 1950

5. SEX: Female
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: JULY 31 1882
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months 7, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): Mo., D
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JOHN WILLER
13b. MOTHER'S MAIDEN NAME: ANNA EICHELMANN
14. NAME OF HUSBAND ~~OR WIFE~~: OTTO GARBS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: OTTO GARBS — ADDRESS: 1710 S. 7th ST.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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): 332X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/22/50, 19__, *to* 3/28/50, 19__, *that I last saw the deceased alive on* 3/28/50, 19__ *and that death occurred at* 9:10PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. Lauermann M.D.
23b. ADDRESS: 1515 Lafayette Ave.,
23c. DATE SIGNED: 3/28/4

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: MAR. 31 1950
24c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM
24d. LOCATION (City, town, or county) (State): ST. LOUIS MO

DATE REC'D BY LOCAL REG.: MAR 30 1950
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Thomas Kuti — ADDRESS: 2916 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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 Leo J. Budde

Licensed Embalmer No. 3989

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.