

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21939**
5266

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) 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 2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1906 Clara Ave.		d. STREET ADDRESS (If rural, give location) 1906 Clara Ave	

3. NAME OF DECEASED (Type or Print) a. (First) Gertrude b. (Middle) M. c. (Last) Rebori	4. DATE OF DEATH (Month) (Day) (Year) June 13 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/17/1888	9. AGE (In years last birthday) (Month) (Day) (Min.) 61 3 22
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Patrick Ryan	13b. MOTHER'S MAIDEN NAME Maggie Kennedy	14. NAME OF HUSBAND OR WIFE Paschal Rebori
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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.	17. INFORMANT'S SIGNATURE OR NAME Paschal Rebori	ADDRESS 1906 Clara Ave.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 15 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		
	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. Pernicious Anaemia		20 yrs	

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	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)
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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? 2nd
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22. I hereby certify that I attended the deceased from **1-10**, 19**30**, to **6-12**, 19**50**, that I last saw the deceased alive on **6-12**, 19**50**, and that death occurred at **2:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE Dr. H. K. Kunkel	(Degree or title) M.D.	23b. ADDRESS 540 Bermuda	23c. DATE SIGNED 6-15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/16/50	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. JUN 15 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Sullivan Funeral Dir. 2849 N. Euclid
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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 _____

working under my personal supervision.

Signed

Robert L. Brinkman
Student Embalmer No.

Signed.....
Student Embalmer

Licensed Embalmer No. *3553*

P. O. Address *St Louis*

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.