

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28278
7226
Registrar's No.

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. 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 2679	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) 5519 Milentz Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Desloge Hospital			

3. NAME OF DECEASED (Type or Print) VINCENT	a. (First) T.	b. (Middle) HERBERS Sr.	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Aug. 23 1950
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2	8. DATE OF BIRTH April 5, 1888	9. AGE (In years last birthday) 62	10. UNDER 1 YEAR Months	11. UNDER 1 YEAR Days	12. UNDER 1 YEAR Hours	13. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 2 Yrs.	10b. KIND OF BUSINESS OR INDUSTRY Famous-Barr Co.	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U
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13a. FATHER'S NAME John J. Herbers	13b. MOTHER'S MAIDEN NAME Catherine Schmucker	14. NAME OF HUSBAND OR WIFE Late Nell K. Herbers
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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) Yes World War 1	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Vincent T. Herbers Jr.	18. ADDRESS 5519 Milentz
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma Esophagus</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 150X
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22. I hereby certify that I attended the deceased from Aug 9, 1950 to Aug 23, 1950, that I last saw the deceased alive on Aug 22, 1950, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE J. B. Laster	23b. ADDRESS 3220 Washington Ave	23c. DATE SIGNED 8-24-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11	24b. DATE Aug. 26, 1950	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. AUG 24 1950	REGISTRAR'S SIGNATURE J. B. Laster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 15 1950

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.

Student Embalmer No.....

Signed.....

Richard W. Stovessand

Signed.....
Student Embalmer

Licensed Embalmer No. 4007

P. O. Address.....

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.