

FILED MAR 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6135

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1471**

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)	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
3. NAME OF DECEASED (Type or Print)		d. STREET ADDRESS (If rural, give location)	
a. (First) William	b. (Middle)	e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. (Last) Grab		d. STREET ADDRESS 24 2914 Texas Ave.	
4. DATE OF DEATH (Month) (Day) (Year) February 13, 1951		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH April 10, 1861		9. AGE (In years last birthday) 89	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany 4		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Not known		13b. MOTHER'S MAIDEN NAME Not known	
14. NAME OF HUSBAND OR WIFE		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 ADDRESS William Kohlschreiber 3442 Connecticut St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES		DUE TO (b)	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		Coronary Thrombosis	
II. OTHER SIGNIFICANT CONDITIONS		DUE TO (c)			
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"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR H/201	

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 1235 P m., from the causes and on the date stated above.

23a. SIGNATURE Carol E. Taylor Coronel (Degree or title)		23b. ADDRESS 1500 Clark		23c. DATE SIGNED 2.13.51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2/15/51		24c. NAME OF CEMETERY OR CREMATORY St. Mathews Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		DATE REC'D BY LOCAL REG. FEB 13 1951		REGISTRAR'S SIGNATURE J.B. Kasater	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H. Gebken Sons 2630 Gravois Ave.					

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 Robert F. Gebken.....

Licensed Embalmer No. 4144.....

P. O. Address 2630 Gravois Ave......

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.