

FILED NOV 14 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37146

BIRTH NO.		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 547		Registrar's No. 2739	
1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS			
b. CITY (If outside corporate limits, write RURAL and give township) RICH. HGTS.		c. LENGTH OF STAY (in this place) 10 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OVERLAND 4221		d. STREET ADDRESS (If rural, give location) 9109 E. MILTON	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. MARYS HOSP.							
3. NAME OF DECEASED (Type or Print) CHARLES		a. (First) E.		b. (Middle) DERBAK		c. (Last) DERBAK	
4. DATE OF DEATH		OCT. 22 1952		5. SEX M		6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH AUG. 2 1951		9. AGE (In years last birthday) 1 2 20		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY BOY	
10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and State or Foreign Country) CASPER WYOMING		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME NICHOLAS DERBAK		13b. MOTHER'S MAIDEN NAME MARY WYBOP		14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME NICHOLAS DERBAK		ADDRESS 9109 E. MILTON	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary DUE TO (c) 355X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Brain tumor type(?)				INTERVAL BETWEEN ONSET AND DEATH 10 min. 30 min.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Tumor like mass left parietal region -				20. AUTOPSY? YES <input checked="" 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?			
22. I hereby certify that I attended the deceased from Oct 15, 1952, to Oct 22, 1952, that I last saw the deceased alive on Oct 22, 1952 and that death occurred at Overland, from the causes and on the date stated above.							
23a. SIGNATURE Le Roy Josephine M.D. (Name or title)				23b. ADDRESS 3786 Leander		23c. DATE SIGNED 10-23-52	
24a. BURIAL, CREMATION, REMOVAL		24b. DATE OCT. 24, 1952		24c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVE CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo.	
DATE REC'D BY LOCAL REG. 10-23-52		REGISTRAR'S SIGNATURE Herbert R. Dombi - M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Q. H. Backlager 6536 Clayton St.			

P.T. (Licensed Embalmer's Statement on Reverse Side)

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

305  
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**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 M. Murray*

Licensed Embalmer No. *37491*

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.