

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11828

State File No. 2484

FILED MAR 24 1953
BIRTH NO. 18239 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 3 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Hospital		c. CITY (If outside corporate limits, write RURAL and give township) Lemay	
		d. STREET ADDRESS (If rural, give location) 1022 Kilner St.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Susan	b. (Middle) Marie	c. (Last) Kobermann	March 4, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 3, 1953		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.

13a. FATHER'S NAME William Kobermann	13b. MOTHER'S MAIDEN NAME Dorothy Vormehr	14. NAME OF HUSBAND OR WIFE
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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 William Koberman	ADDRESS 1022 Kilner Lemay, Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pericarditis with (7 mo.)</i>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Coronary arteriosclerosis.</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <i>Bronchial cyst. neck.</i>		

19a. DATE OF OPERATION	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)	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? <i>774X</i>

22. I hereby certify that I attended the deceased from *Mar 3, 1953*, to *Mar 4, 1953*, that I last saw the deceased alive on *Mar 4, 1953*, and that death occurred at *11:30 P.M.* from the causes and on the date stated above.

23a. SIGNATURE <i>Paul Whippers m.d.</i>	(Degree or title)	23b. ADDRESS <i>7702 Loring Ave</i>	23c. DATE SIGNED <i>3/5/53</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE March 6, 1953	24c. NAME OF CEMETERY OR CREMATORY SS-Peter & Paul Cemetery	24d. LOCATION (City, town, or county) (State) 7020 Gravois ave
DATE REC'D BY LOCAL REG. MAR 5 1953	REGISTRAR'S SIGNATURE <i>J. Earl Smith, m.d.</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>C. Hoffmeister U.&.L.Co. 7814 S. Broadway</i>	

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 Frank J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 7814 1/2 Broadway

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.