

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37350

State File No. ....

FILED OCT 29 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9967**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>2-yrs.</b>	c. CITY OR TOWN <b>St. Louis</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3225 N. Florissant Ave. Little Sisters of Poor</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>20 3225 N. Florissant Ave.</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Julia</b> b. (Middle) <b>T.</b> c. (Last) <b>Kribs</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 18, 1953</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>June 17, 1869</b>
9. AGE (In years less birthday) <b>84</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 1 YEAR Days <b>1</b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Red Bud, Ill.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>Peter J. Kribs</b>		13b. MOTHER'S MAIDEN NAME <b>Augusta L. Homes</b>	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) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Estelle Scott, 3930a Shaw Blvd.</b>
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Ch. Myocarditis. Seizure</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Hemorrhage</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <input checked="" type="checkbox"/>	
INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mo.</b>			
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	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) m. <b>None</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4222</b>	
22. I hereby certify that I attended the deceased from <b>Sept 1, 1953</b> , to <b>Oct 18, 1953</b> , that I last saw the deceased alive on <b>Oct 11, 1953</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Edward J. Flotte, M.D.</b>		23b. ADDRESS <b>2435 N. Grand Blvd.</b>	23c. DATE SIGNED <b>10-19-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Oct. 21, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
DATE REC'D BY LOCAL REG. <b>OCT 19 1953</b>	REGISTRAR'S SIGNATURE <b>J. Charles Smith</b>	FUNERAL DIRECTOR'S SIGNATURE <b>J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>

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.....  
Signature of Student Embalmer

Signed.....  
*Wm. J. Loper*  
*Frank A. Williams*

Licensed Embalmer No. *469*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.