

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35478

BIRTH NO. 73416-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9259

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 2169 16 3937 Humphrey	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hosp.		3. NAME OF DECEASED (Type or Print) a. (First) Susan b. (Middle) — c. (Last) HoGrebe	
4. DATE OF DEATH (Month) (Day) (Year) 10-12-54		5. SEX F 6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH 10-7-54	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Robert. HoGrebe		13b. MOTHER'S MAIDEN NAME ZONA Buchner	
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 Robert HoGrebe 3937 Humphrey St	
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) Atelectasis ANTECEDENT CAUSES DUE TO (b) Prematurity 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"/>		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) 762.5	
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?		22. I hereby certify that I attended the deceased from 10/7, 1954, to 10/17, 1954, that I last saw the deceased alive on 10/11, 1954, and that death occurred at 9:30 a.m., from the causes and on the date stated above.	
23a. SIGNATURE Jackson Gto		23b. ADDRESS MO 634 No Name	
23c. DATE SIGNED 10/12/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 10-13-1954		24c. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery	
24d. LOCATION (City, town, or county) (State) 6638 Gravois Ave MO		DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 13 1954	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		MO Siegenlander 6409 Gravois Ave	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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 _____

not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Jan M. Szymore

Licensed Embalmer No. _____

4343

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.