

FILED APR 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14226

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>766</u>				
1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u>				b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>RICHMOND HEIGHTS</u>)			c. LENGTH OF STAY (If in this place) <u>3 days</u>		c. CITY OR TOWN <u>ST LOUIS</u>		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARY'S HOSPITAL</u>				7a. STREET ADDRESS (If rural, give location) <u>4217 DE SOTO AVE</u>				2101		
3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u>			b. (Middle) <u>G.</u>		c. (Last) <u>KOBUSCH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 2, 1955</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>		8. DATE OF BIRTH <u>AUG. 16, 1919</u>		9. AGE (In years last birthday) <u>5</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ST LOUIS MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13a. FATHER'S NAME <u>MELVIN KOBUSCH</u>			13b. MOTHER'S MAIDEN NAME <u>BERNICE BANGE</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MELVIN KOBUSCH</u>				ADDRESS <u>4217 DESOTO AVE</u>	
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) _____ ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Brain Tumor</u> DUE TO (c) <u>Malignant</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>		
19a. DATE OF OPERATION <u>4-2-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Same</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>4-1, 1955</u> to <u>4-2, 1955</u> , that I last saw the deceased alive on <u>4-2, 1955</u> , and that death occurred at <u>5:45 p.m.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>Robert W. Wootley M.D.</u>				23b. ADDRESS <u>6944 CHIPPEWA</u>				23c. DATE SIGNED <u>4-4-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Re Burial 4/5/55</u>		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>		24d. LOCATION (City, town, or county) <u>ST LOUIS MISSOURI</u>		(State) _____		
DATE REC'D BY LOCAL REG. <u>4-4-55</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donker M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STROOT - CARROLL</u>		ADDRESS <u>1600 NATURAL BRIDGE AVE</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

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Dr
Robertson
16. W. Wash
Hampton Village
2, 22 1-12-61
ABOUT - 12:00 TO 1:30

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 *John J. Harris*
Licensed Embalmer No. *410*
P. O. Address *Harris*

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.