No. 300
10.48

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30606

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8230

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place) 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8665 Partridge

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location) 8665 Partridge 2087

3. NAME OF DECEASED (Type or Print) a. (First) Lawrence b. (Middle) c. (Last) Bober
4. DATE OF DEATH (Month) (Day) (Year) Sept 18 1955
5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH Feb. 1 1952
9. AGE (In years last birthday) 3 — If under 1 year: Months, Days — If under 1 hr.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Bernard Bober
13b. MOTHER'S MAIDEN NAME Emma Moor
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernard Bober 8665 Partridge

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma Mediastinal — INTERVAL BETWEEN ONSET AND DEATH: 5 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Leukemia — 1 mos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 200.1
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-15, 1955, *to* 9/18, 1955, *that I last saw the deceased alive on* 9/18, 1955, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] (Degree or title) DO
23b. ADDRESS 5329 Riverview Blvd
23c. DATE SIGNED 9/18/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/21/55
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) St. Louis (State) Mo.

DATE REC'D BY LOCAL REG. SEP 20 1955
REGISTRAR'S SIGNATURE [illegible] MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz Mortuary 5967 W. Florissant
(Licensed Embalmer's Statement on Reverse Side)

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 emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision:.

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.