

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED SEP 29 1955

State File No. **31316**

318

PRIMARY REG. DIST. NO. **1003** Registrar's No. **7982**

1. PLACE OF DEATH a. COUNTY Missouri			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 16 days	c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital			e. STREET ADDRESS (If rural, give location) 23 2500 South 18th Street		
3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) c. (Last) Pabst			4. DATE OF DEATH (Month) (Day) (Year) 9/9/ 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 7/15/1873	9. AGE (In years Last birthday) 82	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Adam Bolgard		13b. MOTHER'S MAIDEN NAME Wilhelmina Greibel		14. NAME OF HUSBAND OR WIFE Late William H. Pabst	
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 ADDRESS Chronic Hospital, 5600 Arsenal			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerosis.					INTERVAL BETWEEN ONSET AND DEATH years
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis 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 334X			
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)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 8/24 , 19 55 , to 9/9 , 19 55 , that I last saw the deceased alive on 9/9 , 19 55 , and that death occurred at 2:12 PM from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) George M. Janaka, M.D.			23b. ADDRESS 5600 Arsenal		23c. DATE SIGNED Sept. 10, 1955
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Sep. 12, 1955	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. SFP 12 1955		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.	

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... *Richard W. Stovesand*

Licensed Embalmer No. *4007*

P. O. Address

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.