

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42287

State File No.

FILED JAN 6 1956

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 11348

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 10 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
3. NAME OF DECEASED (Type or Print) Samuell Marshall Korb		d. STREET ADDRESS (If rural, give location) 12 4903 Delmar Bl.	
a. (First)	b. (Middle)	c. (Last)	
4. DATE OF DEATH 12/24/55		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
8. DATE OF BIRTH 12/1/97		9. AGE (In years last birthday) 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Oil Contracts	
11. BIRTHPLACE (State or foreign country) Louisville Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Benj. Korb		13b. MOTHER'S MAIDEN NAME Minnie Steubing	
14. NAME OF HUSBAND OR WIFE Madge Korb Dowd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No None	
16. SOCIAL SECURITY NO. 350-09-4668		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Morcha Whelan 7520 York Av. Clayton, Mo.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Retroperitoneal Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Subdural Mass Hemorrhage & rupture retro-peritoneally. 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 541.0	
20. AUTOPSY YES <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		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 12/20 , 19 55 , to 12/24 , 19 55 , that I last saw the deceased alive on 12/24 , 19 55 , and that death occurred at 1 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE D. B. Glavan M.D.		23b. ADDRESS 539 N. Grand Bl. St. Louis	
23c. DATE SIGNED 12/27/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12/28/55		24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS LAWRENCE MULLEN & SONS 5165 Delmar Bl.	
DATE REC'D BY LOCAL REG. DEC 27 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	

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
Student Embalmer

Signed Ronald O Yaburke

Licensed Embalmer No. 3917

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 this body is not embalmed, fact should be so stated above.