

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 25 1956

State File No. **17754**
Registrar's No. **4197**

318 REG. DIST. NO. **1003** PRIMARY REG. DIST. NO.

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 OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) 3 1/2 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.		c. CITY OR TOWN St. Louis	
3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) Deboe c. (Last)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow		8. DATE OF BIRTH 6-21-1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		9. AGE (In years last birthday) 82	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Ky.	
13a. FATHER'S NAME Wm. Barber		13b. MOTHER'S MAIDEN NAME Elizabeth Field	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		14. NAME OF HUSBAND OR WIFE Late James E. Deboe	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Hospital Records ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertensive Cardiovascular Disease	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) Cerebral Arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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?		443x	
22. I hereby certify that I attended the deceased from 10-30-53 , 19___, to 4-27-56 , 19___, that I last saw the deceased alive on 4-27-56 , 19___, and that death occurred at 2:50 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE George M. Janaka, M.D. (Degree or title)		23b. ADDRESS 5800 Arsenal St.	
23c. DATE SIGNED Apr. 28, 1956		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail)	
24b. DATE 4-28-1956		24c. NAME OF CEMETERY OR CREMATORY Clinton, Kentucky	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshausler ADDRESS 4228 S. Kingshighway Bl.	
DATE REC'D BY LOCAL REG. APR 28 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.	

m83- (Licensed Embalmer's Statement on Reverse Side)

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 *William B. White*.....

Licensed Embalmer No. *522*

P. O. Address *228 1/2*

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