

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32579

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 548 Registrar's No. 2168

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				c. CITY OR TOWN <u>Riverview Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		4010/	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. St. Louis Co. Hospt.</u> Length of stay in lb				d. STREET ADDRESS <u>9758 Diamond Dr.</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Rabus</u> Last <u>Rabus</u>			4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6 1897</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Riverview School</u>		11. BIRTHPLACE (City and state or country) <u>Chorzow, Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>(D.P.) Poland</u>	
13. FATHER'S NAME <u>(Unknown)</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown)</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>490-36-6761</u>		17. INFORMANT (cousin) Address <u>Richard R. Rabus 9922 Diamond Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self-inflicted strangulation by ligature</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Body found hanging by a clothesline type rope</u>					
20c. TIME OF INJURY <u>5:00 P.M.</u> Hour <u>9</u> Month <u>12</u> Day <u>56</u> Year		fastened to an overhead rafter in the garage on the property of Louis Brolaski, from whom he rents a basement apartment					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>garage</u>		20f. CITY, TOWN, OR LOCATION <u>Riverview Gardens St. Louis Mo.</u>			
21. I attended the deceased from _____, to _____ and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Ernest J. Hillman</u> (Degree or title) <u>Coroner Clayton 5, Mo.</u>				22b. ADDRESS		22c. DATE SIGNED <u>9/17/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/14/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Robert D. Kinealy 2228 St. Louis</u>				25. DATE RECD. BY LOCAL REG. <u>Ave. 9-14-56</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Douke md.</u>	

**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

*Robert D. Finley*  
Signed.....  
Robert D. Finley  
Licensed Embalmer No.....  
Funeral Director  
P. O. Address.....

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