

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 2 2 8 3 4  
STATE FILE NUMBER  
318 Primary Registration District No. 1003 Registrar's No. 5328

FILED JUN 20 1957

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <input checked="" type="checkbox"/> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>                         |  | c. CITY OR TOWN <b>St. Louis</b>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1</b> |  | d. STREET ADDRESS (If outside, give location) <b>2822a Park Ave.</b>  |  |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) <b>TILLIE</b> First <b>ROBAEK</b> Middle Last |  |  | 4. DATE OF DEATH <b>JUNE 5, 1957</b> Month Day Year |  |  |
|---|--|--|---|--|--|

|                      |                               |  |                                  |   |   |                  |
|----------------------|-------------------------------|--|----------------------------------|---|---|------------------|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>2/2/1888</b> | 9. AGE (In years last birthday) <b>69</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS. |
|----------------------|-------------------------------|--|----------------------------------|---|---|------------------|

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|--|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <b>Galicia, Austria</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
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|---|--|--|--|
| 13. FATHER'S NAME <b>Peter Zarabinski</b> |  | 14. MOTHER'S MAIDEN NAME <b>Julia Lesoba</b> |  |
|---|--|--|--|

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|---|-------------------------------------|---|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b> | 16. SOCIAL SECURITY NO. <b>None</b> | 17. INFORMANT <b>Thomas Robaek</b> Address <b>2822a Park Ave.</b> |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF RECTUM<br/>CIRRHOSIS OF LIVER - LAENNEC'S</b>                                  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS ASHD &amp; MILD CHF, CHRONIC BRAIN SYNDROME ON ARTERIOSCLEROTIC BASIS.</b> |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
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|  |  |   |   |
|--|--|---|---|
| 20c. TIME OF INJURY Hour <b>10:40</b> Month, Day, Year <b>6/5/57</b> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
|--|--|---|---|

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|--|--|
| 21. I attended the deceased from <b>4/23/57</b> to <b>6/5/57</b> and last saw her alive on <b>6/5/57</b><br>Death occurred at <b>10:40 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |
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|   |   |                                |
|---|---|--------------------------------|
| 22a. SIGNATURE (Degree or title) <b>Robert L. Trayer M.D.</b> | 22b. ADDRESS <b>1515 LAFAYETTE AVE.</b> | 22c. DATE SIGNED <b>6/6/57</b> |
|---|---|--------------------------------|

|  |                         |   |  |
|--|-------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> | 23b. DATE <b>6/8/57</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b> | 23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b> |
|--|-------------------------|---|--|

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| 24. FUNERAL DIRECTOR <b>CHULICK UND. CO. 1722 S. Jefferson</b> | 25. DATE RECD. BY LOCAL REG. <b>JUN-7 '57</b> | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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Obtain similar form to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed *Harvey F. Kahl*.....

Licensed Embalmer No. *45*

P. O. Address *Flattis*

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.