

Health,  
& Welfare  
S. Public  
ith Service

FILED DEC 9-1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43046

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2899

S. 800  
v. -57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Oakville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Oakville</u> <u>4000</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Erb Road</u> INSTITUTION		Length of stay in lb <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>Erb Road Box 584 Rt 9</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>T.</u> Last <u>Erb</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>18,</u> Year <u>1957</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1895</u>	9. AGE (In years last birthday) <u>62</u>	FUNERAL YEAR 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) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Oakville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George H. Erb</u>	13b. MOTHER'S MAIDEN NAME <u>Sophie Kraus</u>	14. NAME OF HUSBAND OR WIFE <u>Adele Koch Erb</u>
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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) <u>Yes WW I</u>	16. SOCIAL SECURITY NO. <u>492 16 3189</u>	17. INFORMANT Address <u>Adele Erb Rt 9 Box 584 Oakville, Mo.</u>
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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>Acute dilatation of heart</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>chronic cardiac vascular disease</u> DUE TO (c) <u>4221</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>Several yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 11-9-57 to 11/18/57 and last saw her alive on 11/18/57  
Death occurred at 4A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Oscar T. Erb</u> (Deceased or title)	22b. ADDRESS <u>752 Leeway Ferry Rd</u>	22c. DATE SIGNED <u>11/18/57</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 20, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>	23d. LOCATION (City, town, or county) <u>Oakville, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Holmeister Mortuaries 7814 So. Broadway St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-19-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert K. Somberg</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Lenius C. Hoffmeier* .....

Licensed Embalmer No. *3871* .....

P. O. Address *7814 S. Broad* .....

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.