

Health, Welfare Public Service
300
1-58
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. No 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. No symptoms will be listed. No standard nomenclature in item 18. No standard nomenclature in item 18.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4051

FILED JAN 13 1958

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 11

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) OR TOWN <u>Belridge</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Belridge 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 INSTITUTION <u>3335 Carson Rd. 21</u>			Length of stay in 1b <u>10 Years</u>		d. STREET ADDRESS (If outside, give location) <u>3335 Carosn Road, 21</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLOTTE</u> Middle <u>ANNA</u> Last <u>TEBBE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>1st</u> Year <u>1958</u>				
5. SEX <u>Female</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>July 11th, 1871</u>		9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Bockhorst, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Becker</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>None</u>		17. INFORMANT <u>Edward H. Tebbe, 3335 Carson Road, 21,</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>Generalized Arteriosclerosis</u> <u>Cardiac Hypertrophy</u> <u>Chronic Myelonephritis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>6000</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
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.) <u> </u>					
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>			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.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>		STATE <u> </u>		
21. I attended the deceased from <u>7-29-43</u> to <u> </u> and last saw her <u> </u> alive on <u>1-1-58</u> Death occurred at <u>9:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert B. Donk MD</u>				22b. ADDRESS <u>6876 Natural Bridge</u>		22c. DATE SIGNED <u>1-3-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/4/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri</u>			
24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ, 4828 Natural Bridge Blvd.,</u> FUNERAL HOME, St. Louis, 15, Missouri			25. DATE RECD. BY LOCAL REG. <u>1-3-58</u>		26. REGISTRAR'S SIGNATURE <u>Robert B. Donk MD</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

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

Student.....
Signature of Student Embalmer

Signed *Ralph C. Lindus*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.