

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003957  
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 317

300  
-57

Health,  
Welfare  
Public  
Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use any standard nomenclature in Part I. All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Johns</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>St. Johns 42110</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3573 Eminence</b>		Length of stay in lb <b>50 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>3573 Eminence</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louis Faerber</b>			4. DATE OF DEATH Month Day Year <b>1/31/59</b>
5. SEX <b>Male</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>Mar. 4, 1877</b>
9. AGE (In years, last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landscaping</b>	11. BIRTHPLACE (City and state or country) <b>Herman, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Valentine Faerber</b>	
13b. MOTHER'S MAIDEN NAME <b>Magdalena Gleisner</b>		14. NAME OF HUSBAND OR WIFE <b>Gatherine Faerber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None.</b>	17. INFORMANT <b>Gatherine Faerber</b> Address <b>St. Johns, Mo 3573 Eminence</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bio-lateral Hemiplegia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>3 years</b>
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.) _____	
20c. TIME OF INJURY Hour Month, Day, Year a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <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 _____	
21. I attended the deceased from <b>6-10-55</b> to <b>1-31-59</b> and last saw him alive on <b>1-30-59</b> Death occurred at <b>6:00</b> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Herman J. Kloster M.D.</b> (Degree or title)		22b. ADDRESS <b>9616 Loddland Rd</b>	22c. DATE SIGNED <b>1-31-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/3/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>Ortmann F. Home</b> ADDRESS <b>9222 Lackland</b>		25. DATE RECD. BY LOCAL REG. <b>2-2-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>

Overland (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 *Al C. Ostmann* .....

Licensed Embalmer No. *3478* .....

P. O. Address .....

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.