

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

59-014693  
 STATE FILE NUMBER

300

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 1 1959		Registration District No. _____		Primary Registration District No. _____		Registrar's No. <b>3577</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</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>Little Sisters of The Poor</b>		Length of stay in lb <b>6 Yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>35 Vandervanter Pl</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle _____ Last <b>Binig</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>About Sept. 14, 1882</b>	
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b>		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Roumania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13a. FATHER'S NAME <b>Maisa Binig</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Teolia</b>			14. NAME OF HUSBAND OR WIFE <b>Dont Know</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>490-07-1044</b>		17. INFORMANT Address <b>Sr. Marie Jean, Supr., 3400 S. Grand Ave.</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>Arteriosclerotic Heart Dis.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Gen. Arteriosclerosis</b> DUE TO (c) <b>420-0</b>						INTERVAL BETWEEN ONSET AND DEATH <b>yr</b> <b>yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 Death occurred at <b>9:00 A. M.</b> on <b>4/10/59</b> to <b>4/10/59</b> and last saw him alive on <b>4/9/59</b>							
22a. SIGNATURE <b>Truzyera md</b> (Degree or title)			22b. ADDRESS <b>8059 Watson Rd.</b>			22c. DATE SIGNED <b>4/10/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/13/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
24. FUNERAL DIRECTOR <b>Gebken Sons</b> ADDRESS <b>2630 Gravois Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>APR 10 1959</b>		26. REGISTRAR'S SIGNATURE <b>Roald Smith M.D.</b>		

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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 *Robert J. Gebel*

Licensed Embalmer No. 4144  
P. O. Address 2630 Gravois Av

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.