

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018955
STATE FILE NUMBER
2 4515

FILED MAY 18 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

300
-57
31
91
0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hosp.		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 5400 Arsenal St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) CLIFFORD BOBE			4. DATE OF DEATH Month May Day 6th , Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-1880	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Peter Bobe	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE —
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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) No	16. SOCIAL SECURITY NO. —	19. INFORMANT Walter Bobe Address 5718 Chippewa St.
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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) Arteriosclerotic heart disease with congestive failure.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bronchiectasis, left, with cavitation, abscesses and gangrene.	
	DUE TO (c) Rheumatic mitral valvulitis with moderate stenosis.	
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 checked="" type="checkbox"/> NO <input 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.) 420.0
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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 St. Louis	COUNTY St. Louis	STATE Mo
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21. I attended the deceased from Feb. 11, 1911 to May 6, 1959 and last saw him alive on May 6, 1959 Death occurred at 8:25 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE John H. Weisbach M.D. (Degree or title)	22b. ADDRESS 5400 Arsenal St.,	22c. DATE SIGNED 5-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-8-1959	23c. NAME OF CEMETERY OR CREMATORY Old St. Marcus Cemetery	23d. LOCATION (City, town, or county) (State) 6638 Gravois Ave Mo
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FUNERAL DIRECTOR Beigenheim Bros ADDRESS 6409 Gravois Av	25. DATE RECD. BY LOCAL REG. MAY 8 '59	REGISTRAR'S SIGNATURE Earl Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Law M. Signore*

Licensed Embalmer No. *4343*

P. O. Address *St Louis Mo*

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.