

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019018  
STATE OF MISSOURI  
24980

FILED JUN 4 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>De Paul Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>651 Adrian Dr.</b>	
Length of stay in 1b <b>4-1/2 Weeks</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Girard</b> Last <b>Carbrey</b>			4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1959</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>Oct. 29, 1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Police Dept.</b>	9. AGE (In years last birthday) <b>42</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Sylvester P. Carbrey</b>		13b. MOTHER'S MAIDEN NAME <b>Mary J. Tully</b>	14. NAME OF HUSBAND OR WIFE <b>Eunice Carbrey</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mrs. Eunice Carbrey</b>		Address <b>651 Adrian Dr.</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>acute stem cell leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>2043</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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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		COUNTY	STATE
21. I attended the deceased from <b>April 5, 1959</b> to <b>5/20/59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>5/20/59</b> Death occurred at <b>8:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert Plashnick M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	
(Degree or title)		22c. DATE SIGNED <b>5/22/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>May 25, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>
23d. LOCATION (City, town, or county) <b>St. Louis</b>		23e. STATE <b>Missouri</b>	
24. FUNERAL DIRECTOR <b>Math Hermann &amp; Son Inc.</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 22 '59</b>	
ADDRESS <b>2161 E. Fair</b>		26. REGISTRAR'S SIGNATURE <b>Karl Smith M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

S.P.

Health, Welfare, Public Service

300  
-57  
0  
94

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Clement M. Neary*

Licensed Embalmer No. *3732*  
P. O. Address *St. Louis*

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.