Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019678
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 4826

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST. LOUIS, MISSOURI — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: BARNES HOSPITAL — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: ST. LOUIS — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5505 VERMONT — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: LOUIS Middle: F. Last: STROBACK

4. DATE OF DEATH: Month, Day, Year: MAY 17, 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JUNE 9, 1890
9. AGE (In years last birthday): 68 — 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): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: MACHINIST HELPER
11. BIRTHPLACE (City and state or country): GRANGER, TEXAS
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: FRANK STROBACK
13b. MOTHER'S MAIDEN NAME: THERESA SCHINDLER
14. NAME OF HUSBAND OR WIFE: MARCIA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MARCHA STROBACK — Address: 5505 VERMONT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA OF STOMACH — INTERVAL BETWEEN ONSET AND DEATH: 2/ YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 151 X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): RENAL FAILURE, ETIOLOGY UNKNOWN
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 NOVEMBER 11, 1958, to MAY 17, 1959 and last saw her/him alive on MAY 17, 1959
Death occurred at 9:10 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: C. Vermillion, M.D. (Degree or title): M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 5/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 5/20/1959
23c. NAME OF CEMETERY OR CREMATORY: PARK LAWN CEMETERY
23d. LOCATION (City, town, or county) (State): ST. LOUIS CO., MO.

24. FUNERAL DIRECTOR: J L ZIEGENHEIN & SONS — ADDRESS: 7027 GRAVOIS
25. DATE REC'D. BY LOCAL REG.: MAY 18 '59
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 Donald E Berg

Licensed Embalmer No. 4863

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.