

pt. Health,
, & Welfare
S. Public
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-026582

STATE FILE NUMBER

2 6130

FILED JUL 17 1959 Registration District No. Primary Registration District No. Registrar No.

S. 300
ev. 1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Des Peres 4000 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarinate Word Hosp.		Length of stay in lb 1 day	d. STREET ADDRESS (If outside, give location) #8 Claychester Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Katharina Middle (N.M.I.) Last Ebinger			4. DATE OF DEATH Month June Day 29 Year 1959
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Hungary (Nat'l)
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME (unknown) Ehrenreich	
13b. MOTHER'S MAIDEN NAME (unknown)		14. NAME OF HUSBAND OR WIFE Adam Ebinger (Deceased)	
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. None	17. INFORMANT Michael Ebinger #8 Claychester, Des Peres
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE ACUTE DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) BRONCHIAL ASTHMA			INTERVAL BETWEEN ONSET AND DEATH 5 hrs 3 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 24ix			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 1951 to 6/29/59 and last seen alive on 6/29/59 Death occurred at 10:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Michael M.D. (Degree or title)		22b. ADDRESS 812 Olive	22c. DATE SIGNED 6/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-1-59	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY ADDRESS 6464 CHIPPEWA STREET, ST. LOUIS		25. DATE RECD. BY LOCAL REG. JUN 24 '59	26. REGISTRAR'S SIGNATURE Paul Smith, M.D. mjb

6464 CHIPPEWA STREET, ST. LOUIS

(caused 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 *Rice C. Drayson*

Licensed Embalmer No. *4764*

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.