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FILED VS AUG 31 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-030430
STATE FILE NUMBER
7569

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 Missouri b. COUNTY St.Louis
b. CITY OR TOWN St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Wellston 4301 — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospt — Length of stay in 1b Unk	d. STREET ADDRESS (If outside, give location) 1571 Ogden Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: William	Middle: F	Last: Greber	4. DATE OF DEATH Month Day Year: 8-13-59		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: 2-9-1895	9. AGE (In years last birthday): 64	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): Public Service	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): St.Louis,Missouri	12. CITIZEN OF WHAT COUNTRY?: USA		
13a. FATHER'S NAME: Frank Greber	13b. MOTHER'S MAIDEN NAME: Rosa Wilhelm	14. NAME OF HUSBAND OR WIFE: Ethel B Greber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.#1	16. SOCIAL SECURITY NO.: Unk.	17. INFORMANT: Ethel Greber — Address: 1571 Ogden Ave.			

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) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8/12/59

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chronic Arteriosclerotic heart disease

DUE TO (c) Hypertension & Decompensation

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4201

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 9/2/48, to 8/13/59 and last saw him alive on 8/12/59

Death occurred at 12:15a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Wm E. Moore	(Degree or title): MD	22b. ADDRESS: 7315 Pasadena Blvd	22c. DATE SIGNED: 8/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 8-17-59	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county) (State): St.Louis,Missouri
24. FUNERAL DIRECTOR: J.W.Clark F.H. — ADDRESS: 1125 Hodiamont Ave.	25. DATE RECD. BY LOCAL REG.: AUG 15 '59	26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.	

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 Stanley H. Tipton

Licensed Embalmer No. 4193

P. O. Address D.C.

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.