

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211750** STATE FILE NUMBER

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		c. CITY OR TOWN St. Louis	
Length of stay in 1b Life		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. Anthony's Hospital		d. STREET ADDRESS (If outside, give location) 6935 Sutherland	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Infant (Girl) Gebelein			4. DATE OF DEATH Month Day Year Dec. 18, 1959			
5. SEX Female	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 Dec. 18, '59	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min 59		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis Mo		
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Earl F. Gebelein		13b. MOTHER'S MAIDEN NAME Elaine Gail		
14. NAME OF HUSBAND OR WIFE U. S. A.		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 Earl F. Gebelein		Address 6935 Sutherland				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxia C.E. Fetal Hemorrhage due to rupture of		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) lateral sinus in placenta - at 33w gestation	
	DUE TO (c) 761.5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Placenta previa + transverse position of fetus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.) none
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis	COUNTY Mo.	STATE
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21. I attended the deceased from **birth 7:30am 12/18/59** to **8:20am 12/18/59** and last saw her/him alive on **12/18/59**
Death occurred at **8:20am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) In witness whereof	22b. ADDRESS 3804 Wiltshire Ave	22c. DATE SIGNED 12/18/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/19.59	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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24. FUNERAL DIRECTOR Gebken Sons	ADDRESS 2630 Gravois Ave.	25. DATE RECD. BY LOCAL REG. DEC 18 1959	26. REGISTRAR'S SIGNATURE Earl Smith M.D.
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BY AFFIDAVIT OF BIRTH # 29563 DOCUMENT 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 _____
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert J. Gibbs

Licensed Embalmer No. _____

P. O. Address _____

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.