

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS AUG 24 1960

318 Primary Registration District No. 1003 Registrar's No. 8144 -60-032094  
 STATE FILE NUMBER

IDED

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>	
Length of stay in 1b <b>lifetime</b>		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>3623 S. Spring Ave.</b>		d. STREET ADDRESS (If outside, give location) <b>3623 S. Spring Ave.</b>	
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 <b>MARTHA</b> Middle <b>M.</b> Last <b>DELABAR</b>			4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1960</b>		
5. SEX <b>female</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>8/17/1875</b>	9. AGE (last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>28</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13a. FATHER'S NAME <b>William Grimm</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Heier</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph Delabar</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Theo. F. Delabar - 3623 S. Spring Ave.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>
DUE TO (b) <i>Diabetes Mellitus</i>		
DUE TO (c) <i>H200</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		<i>2 years</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from *2-22-55* to *Aug. 15, 1960* and last saw her *alive on 8-15-60*  
 Death occurred at *home* *7 p.m.* on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>John D. Sertling, M.D.</i>	(Degree or title)	22b. ADDRESS <b>3739 Gravois Ave.</b>	22c. DATE SIGNED <b>8/16/1960</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/18/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Gebken Sons - 2630 Gravois Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 18 1960</b>	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

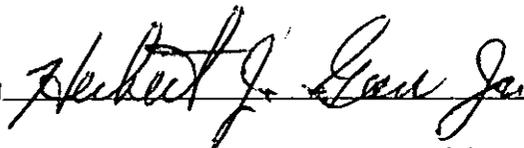
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 4800

P. O. Address Kirkwood 22, 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.