SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

FILED JUL 25 1961

Registration District No. 317 Primary Registration District No. 512 Registrar's No. 1988 STATE FILE NUMBER 61-027865

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Ferguson — Length of stay in 1b: 3 Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Halls Ferry Nursing — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Jennings — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 8927 Berkay — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Home Jeanette — Middle W. — Last Sebastian

4. DATE OF DEATH: Month 7 — Day 15 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2-15-88

9. AGE (last birthday): 73

IF UNDER 1 YEAR: Months — Days. IF UNDER 24 HR: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Henry W. Sebastian

13b. MOTHER'S MAIDEN NAME: Amelia Schulte

14. NAME OF HUSBAND OR WIFE: –

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: William Sebastian, 8927 Berkay

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral hemorrhage	4 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Dis.	5 yrs
DUE TO (c)	Generalized arteriosclerosis	?

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 4-13-54, to 7-15-61 and last saw her alive on 7-13-61

Death occurred at 11:30 Am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Chas. Jost M.D.

22b. ADDRESS: 6000 W Florissant

22c. DATE SIGNED: 7-15-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE: 7-18-61

23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis County Mo.

24. FUNERAL DIRECTOR ADDRESS: Drehmann-Harral, 1905 Union Blvd.

25. DATE RECD. BY LOCAL REG.: 7-17-61

26. REGISTRAR'S SIGNATURE: John E. Murphy M.D.

(Licensed 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_____ Signed Warren A. Carve
Signature of Student Embalmer

Licensed Embalmer No. 353 X

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.