

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035365

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2753

FILED OCT 9 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY ST. LOUIS	b. CITY (If outside corporate limits, give TOWNSHIP only) St. Johns	a. STATE Mo	b. COUNTY st. Louis
Length of stay in 1b over 2 years		c. CITY OR TOWN RUGH MANOR REST HOME	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) RUGH MANOR REST HOME		d. STREET ADDRESS 3326 EMINENCE	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) SENIORA LOBMAN			4. DATE OF DEATH 9 30 61			
5. SEX female	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/11/66	9. AGE (last birthday) 95	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ALABAMA	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME MICHEL LOBMAN		13b. MOTHER'S MAIDEN NAME FANNY KETCH		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 COLEMAN GROSSMAN 1052 TERRACE DR.
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Coronary Thrombosis	DUE TO (b) Arterio-sclerotic - cardiac - vascular disease	10 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		DUE TO (c)

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"/> None	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 a.m. p.m. Month, Day, Year	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 St. Louis Co.
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21. I attended the deceased from 3-8-61 to 9-30-61 and last saw her alive on 9-17-61	
Death occurred at 9-30-61 12:05 p m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Allen M. Kearney M.D.	(Degree or title)	22b. ADDRESS 4308 E. 8th	22c. DATE SIGNED 9-30-61
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 10/1/61	23c. NAME OF CEMETERY OR CREMATORY VALHALLA	23d. LOCATION (City, town, or county) (State) St. Louis Co.

24. FUNERAL DIRECTOR MAYER	ADDRESS 4356 LINDELL BLVD	25. DATE RECD. BY LOCAL REG. 9-30-61	26. REGISTRAR'S SIGNATURE John B. Murphy M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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

John D. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis

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.