

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-029467

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2264

FILED AUG 13 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST LOUIS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton Richmond Hts.</u>		Length of stay in 1b <u>4 years</u>		c. CITY OR TOWN <u>CLAYTON</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6501 CLAYTON RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brother Hubert Maxvelian HERBES</u>			4. DATE OF DEATH Month Day Year <u>Aug 7 1962</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-15</u>	9. AGE (last birthday) <u>47</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>H.S. School</u>		11. BIRTHPLACE (City and state or country) <u>CHICAGO, ILL.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>CASPER HERBES</u>		13b. MOTHER'S MAIDEN NAME <u>CATHERINE DOYLE</u>	
14. NAME OF HUSBAND OR WIFE <u>-</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Dr. Bernard</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic leukemia, chronic</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Insufficiency Due To Inactive Pul. Tuberculosis</u>			
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.)	
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		20g. COUNTY		20h. STATE	
21. I attended the deceased from <u>1935</u> to <u>8/3/62</u> and last saw him alive on <u>8/3/62</u> Death occurred at <u>11:45 PM</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John M. Reine MD</u>			22b. ADDRESS <u>6500 Chiffewa</u>		22c. DATE SIGNED <u>8/4/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-6-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LASALLE INSTITUTE</u>	
23d. LOCATION (City, town, or county) <u>GLENCOE, MISSOURI</u>		24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>		25. DATE RECD. BY LOCAL REG. <u>8-4-62</u>	
24. ADDRESS <u>3840 UNDELL</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address 3840 Indell

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.