

No. 2
4-13-40
5-17-39
PI X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16944

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4462

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:
(a) County Saint Louis, Missouri.
(b) City or town Saint Louis, Missouri.
(c) Name of hospital or institution: Isolation Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Jane Adele Storrjohann,
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female / 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 22nd, 1937.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 7 4 _____ hr. _____ min.

9. Birthplace Saint Louis, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name John Storrjohann
13. Birthplace Saint Louis, Missouri.
(City, town, or county) (State or foreign country)
14. Maiden name Francis Rivley
15. Birthplace Saint Louis, Missouri.
(City, town, or county) (State or foreign country)

16. (a) Informant John Storrjohann
(b) Address 2200 Miami Street.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Park.

18. (a) Signature of funeral director J. Egenheim Broc.
(b) Address 2623 Cherokee Street.

19. (a) MAY 28 1941 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County 000
(c) City or town Saint Louis, Missouri. 2417
(If outside city or town limits, write "RURAL")
(d) Street No. 2200A Miami Street. 9
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th,
year 1941. hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Due to Pertussis
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature [Signature] (M. D. or other) 3
Address [Signature] Date signed 5/28/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

W. Morris

Licensed Embalmer No. *3360*

P. O. Address *2623 Cherokee*

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 this body is not embalmed, fact should be so stated above.