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State File No. _____

FILED JUL 15 1944

Registration District No. 3

Primary Registration District No. 3063

Registrar's No. 1473

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Bellefontaine, Clayton Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Hospital
Olive St. Rd. Chesterfield, Mo. R. 2.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 48 years 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Bellefontaine
(If outside city or town limits, write "RURAL")
(d) Street No. Olive St. Rd. Chesterfield, Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Otto A. Storch
3. (b) If veteran, name war World #1. 3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9
year 1944 hour 11:30 minute 00 A.M.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Katherine Storch 6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased Jan. 25, 1890.
(Month) (Day) (Year)

Immediate cause of death Self-inflicted gun-shot wound of head. Duration _____

8. AGE: Years 54 Months 5 Days 14 If less than one day _____ hr. _____ min.

Due to Gun-shot wound of head.

9. Birthplace St. Louis Co. Mo. 0
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Farmer

Other conditions 164C
(Include pregnancy within 3 months of death)

11. Industry or business Own farm

PHYSICIAN

MOTHER FATHER { 12. Name Frank Storch
13. Birthplace St. Louis Co. Mo. 0
(City, town, or county) (State or foreign country)
14. Maiden name Armina Eisenhardt
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

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

16. (a) Informant Katherine Storch
(b) Address Chesterfield, Mo. R. 2.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof July 12, 44
(Burial, cremation, etc.) (Month) (Day) (Year)
(c) Place: burial or cremation Walton's Cem. Arminia Cemetery
Olive & Woodley Mill Rd. (Specify type of place)

(a) Accident, suicide, or homicide (specify) Suicide.
(b) Date of occurrence July 9, 1944
(c) Where did injury occur? Chesterfield, Mo. (City or town) (County) (State)

18. (a) Signature of funeral director: Arader Funeral Home While at work? _____
(b) Address Ballwin, Mo. (c) Means of injury _____
19. (a) JUL 10 1944 (b) E. J. Hoover (Registrar's signature) Address Clayton, Mo. 7-10-44 Date signed

(d) Did injury occur in or about home, on farm, in industrial place, in public place? On own farm.
(e) Means of injury _____

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

DEC 9 1949

JUL 27 1949

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.....

working under my personal supervision.

Registered Apprentice No.

Signed *Theo. Schrader*

Licensed Embalmer No. *3066*

P. O. Address *Baltimore, Md*

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.