

S. No. 2
OM-5-43
rv. 5-17-39
I X36571

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35899**
Registrar's No. **9705**

FILED NOV 19 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 1/2 days
(Specify whether
 In this community all her life
years, months or days)

3. (a) PRINT FULL NAME Sara Stork

3. (b) If veteran, name war..... **3. (c) Social Security** No.....

4. Sex F **5. Color or race** W **6. (a) Single, widowed, married,** divorced S O

6. (b) Name of husband or wife -- **6. (c) Age of husband or wife if** alive..... years

7. Birth date of deceased April 1 1939
(Month) (Day) (Year)

8. AGE:			Years	Months	Days	If less than one day
			<u>6</u>	<u>7</u>	<u>6</u>	hr. ____ min.

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

10. Usual occupation At school

11. Industry or business.....

MOTHER FATHER

12. Name Walter Stork

13. Birthplace Ft Wayne Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Hepker

15. Birthplace Coffeyville Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Walter Storck, Father

(b) Address 3210 Greer, St Louis Mo

17. (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Nov 10 1945
(Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem

18. (a) Signature of funeral director Beiderwieden F H Inc

(b) Address 1936 St. Louis Avenue

19. (a) NOV 9 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
 (c) City or town St Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3210 Greer
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 7
year 1945 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov. 6, 1945, to Nov. 7, 1945;
that I last saw h. sr. alive on Nov. 7, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Gallop Stroke LHS
Due to.....
Due to.....

Other conditions Septic Meningitis
(Include pregnancy within 6 months of death)

Major findings: Septic Pneumonia
Of operations.....
Of autopsy.....

Duration 3 Days approx
PHYSICIAN
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)
(c) Means of injury

23. Signature C. J. King (M. D. or other) MD
Address 2632 S. KING ST. G. RANDY Date signed 11/8/45

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.....

Delis J. Krispin

Licensed Embalmer No. *3497*

P. O. Address *1936 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 this body is not embalmed, fact should be so stated above.