

FILED AUG 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

27869

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

7202

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: Barnes Hospital,

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution 8 DAYS 19 HOURS
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT JOSEPHINE SUDBRING JOKISCH
FULL NAME

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Roy Elsworth Jokisch 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July 21 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 0 25 hr. min.

9. Birthplace Virginia Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name William O. Sudbrink

13. Birthplace Virginia Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Jennie Taylor

15. Birthplace Virginia Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Roy E. Jokisch

- (b) Address Virginia, Illinois

17. (a) Removal (b) Date thereof 8/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Virginia, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

- (b) Address 4700 Washington Blvd

19. (a) AUG 16 1948

- (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State ILLINOIS (b) County Cass

- (c) City or town VIRGINIA
(If outside city or town limits, write "RURAL")

- (d) Street No. N.R. (If rural, give location)

- (e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 16
year 1948 hour 6 minute 25 a. m.

21. I hereby certify that I attended the deceased from August 7 1948 to August 16, 1948
that I last saw h. or alive on August 16, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to Hemolytic anemia, acquired

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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 F. R. Bradley (M. D. or other) _____

Address Barnes Hospital,

Date signed 8/16/48

(Licensed Embalmer's Statement on Reverse Side)

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.....

Henry M. Brammer

Licensed Embalmer No.....

4200

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