

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35618

State File No. ....

9290

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST LOUIS</b>			c. LENGTH OF STAY (In this place) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4301 So 38<sup>th</sup> St.</b>				d. STREET ADDRESS (If rural, give location) <b>4301 So 38<sup>th</sup> ST</b>					
3. NAME OF DECEASED (Type or Print)		a. (First) <b>LEO</b>		b. (Middle) <b>VICTOR</b>		c. (Last) <b>STORR</b>			
4. DATE OF DEATH		(Month) <b>OCT</b>		(Day) <b>17</b>		(Year) <b>1949</b>			
5. SEX <b>MALE</b>		16. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>SEPT 10, 1894</b>			
9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b>		IF UNDER 1 HR. Hours <b></b> Min. <b></b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <b>JOHN I STORR</b>		13b. MOTHER'S MAIDEN NAME <b>THERESA HOHMANN</b>		14. NAME OF HUSBAND OR WIFE _____					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1<sup>st</sup> WORLD WAR 489-28-5048</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Theresa Storr</b>		ADDRESS <b>4301 So 38<sup>th</sup> St.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____				ANTECEDENT CAUSES					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <b>Coronary Occlusion</b>					
DUE TO (c) _____				DUE TO (c) <b>Coronary Sclerosis</b>					
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <b>MO</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H201</b>					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>8:25 P. m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Walter R. ...</b> (Degree or title) _____				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>10/29/49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>Oct 31-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St Peter + Paul CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO</b>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>OCT 29 1949 J. H. Karater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Robert</b>		ADDRESS <b>Living &amp; 1905 So. Grand</b>					

(Licensed Embalmer's Statement on Reverse Side)

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**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 .....  
Student Embalmer

Signed \_\_\_\_\_

*J. Allen Davis*  
Licensed Embalmer No. 4053

P. O. Address. St. Louis

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

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