

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37154

State File No.

FILED NOV 12 1952
BIRTH NO. 720723 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 2645

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RICHMOND HEIGHTS 6 PAKS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2269	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. MARY'S HOSP. 26		d. STREET ADDRESS (If rural, give location) 2509 A. BLAIR AVE.	
3. NAME OF DECEASED a. (First) PATRICIA b. (Middle) ANN c. (Last) HOLSCHEN.			4. DATE OF DEATH (Month) (Day) (Year) OCT. 13TH 1952
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) CHINA	8. DATE OF BIRTH OCT 7TH 1952
9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months 6	IF UNDER 1 YEAR Days —	IF UNDER 1 YEAR Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO. U	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME CLARENCE J. HOLSCHEN		13b. MOTHER'S MAIDEN NAME MARIE MURRAY	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence J. Holschen 2509a Blair ave	
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sanitation		INTERVAL BETWEEN ONSET AND DEATH Weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diarrhea		
	DUE TO (c) 7640		
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) 7	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 7th 1952 to Oct. 13th 1952 that I last saw the deceased alive on NOV 12, 1952 and that death occurred at 11:20 A.M. from the causes and on the date stated above.			
23a. SIGNATURE Jackson G. ... (Degree or title)		23b. ADDRESS 334 N. Grand	23c. DATE SIGNED 10/13/52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE OCT. 14TH 1952	24c. NAME OF CEMETERY OR CREMATORY ST. FERDINAND	24d. LOCATION (City, town, or county) (State) FLORISSANT MISSOURI
DATE REC'D BY LOCAL REG. 10-13-52	REGISTRAR'S SIGNATURE Herbert R. Dombro, MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brockland and Co. 1827 Hogan St.	

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.

Student
Student Embalmer

Student Embalmer No.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

To be embalmed by John J. Brockland, Undertaker, Brockland Bros.