

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

3733

State File No.

0379

FILED JAN 28 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE Illinois c. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Jacob 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 8	

3. NAME OF DECEASED (Type or Print) ANGELINE Angeline	a. (First)	b. (Middle)	c. (Last) SCHOECK	4. DATE OF DEATH (Month) (Day) (Year) JANUARY 11, 1953
---	------------	-------------	-----------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH July 18, 1872	9. AGE (In years last birthday) 80	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
--------------------------------	---	---	---	---	--------------------------	------------------------	-------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Jacob, Illinois	12. CITIZEN OF WHAT COUNTRY?
--	--	---	-------------------------------------

13a. FATHER'S NAME Henry Rule	13b. MOTHER'S MAIDEN NAME Nancy Waters	14. NAME OF HUSBAND OR WIFE Unknown
--	---	--

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 Mrs. William Schoeck, St. Jacob, Ill.	ADDRESS
--	---	--	----------------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart failure cerebral anoxia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Coronary Arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Neprotic failure - cerebral			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
---	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
---	---	--

22. I hereby certify that I attended the deceased from 1-6-53, 19, to 1-11-53, 19, that I last saw the deceased alive on 1-11-53, 19, and that death occurred at 4:00A m., from the causes and on the date stated above.

23a. SIGNATURE Albert Edward Stock MD	(Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 1-12-53
--	-------------------	---	---

24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-11-53	24c. NAME OF CEMETERY OR CREMATORY St. Jacob, Ill	24d. LOCATION (City, town, or county) (State)
--	------------------------------------	--	--

DATE REC'D BY LOCAL REGISTRAR JAN 13 1953 REG.	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington St. Louis 8, Mo.
---	--	---	---

JAN 13 1953 (Licensed Embalmer's Statement on Reverse Side)

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

No. 300
00.48

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. W. ^{me} Penkley
Licensed Embalmer No. 76531

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.