

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 1 - 1953

State File No. 19313
Registrar's No. 4894

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 19313		Registrar's No. 4894				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____								
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (In this place) _____			c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital				e. STREET ADDRESS (If rural, give location) 45 4654 Delor St.								
3. NAME OF DECEASED (Type or Print) a. (First) ELAINE			b. (Middle) F.		c. (Last) DAECH		4. DATE OF DEATH (Month) (Day) (Year) May 13 1953					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 13, 1914		9. AGE (In years last birthday) 38	10. IF UNDER 1 YEAR Months _____	11. IF UNDER 1 YEAR Days _____	12. IF UNDER 1 YEAR Hours _____	13. IF UNDER 1 YEAR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and State or Foreign Country) Carrolton, Ill.		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME John Brogen			13b. MOTHER'S MAIDEN NAME Ruth Bebe			14. NAME OF HUSBAND OR WIFE Frank Daech						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Daech 4654 Delor St.							
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma of uterus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 6 mos 3 yrs		
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 174X								
22. I hereby certify that I attended the deceased from Jan, 1953, to May 13, 1953, that I last saw the deceased alive on Aug 12, 1953, and that death occurred at 1:30 P.M., from the causes and on the date stated above.												
23a. SIGNATURE (Degree or title) _____				23b. ADDRESS 4952 Maryland Ave				23c. DATE SIGNED 5/14/53				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 16, 1953		24c. NAME OF CEMETERY OR CREMATORY Bethlehem Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.						
DATE REC'D BY LOCAL REG. MAY 14 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.							

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

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.....
Signature of Student Embalmer

Signed *Richard W. Storvick*.....

Licensed Embalmer No. *40*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.