

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34140**

FILED OCT 15 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **9335**

1. PLACE OF DEATH a. COUNTY		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) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1947 Utah St.		e. STREET ADDRESS (If rural, give location) 1947 Utah St.	
3. NAME OF DECEASED (Type or Print) a. (First) Laura (Dale) b. (Middle) G. c. (Last) Storm		4. DATE OF DEATH (Month) (Day) (Year) Sept. 27, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH May 4, 1882
9. AGE (In years less birthday) 71		# UNDER 1 YEAR Months	# UNDER 1 MRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home.	
11. BIRTHPLACE (City and State or Foreign Country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Robert Graff		13b. MOTHER'S MAIDEN NAME Blanche Billingsly	
14. NAME OF HUSBAND OR WIFE Clarence O. Storm			
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 William Storm, 1947 Utah St.		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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) 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 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)			
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? 4222			
22. I hereby certify that I attended the deceased from 700 15, 1952 , to Sept 27, 1953 , that I last saw the deceased alive on Sept 27, 1953 , and that death occurred at 7 P m. , from the causes and on the date stated above.			
23a. SIGNATURE A F Berner (Degree or title) MD		23b. ADDRESS 1259 N. Kings highway Blvd	
23c. DATE SIGNED 9-28-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 9-29-53	
24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
DATE REC'D BY LOCAL REG. SEP 28 1953		REGISTRAR'S SIGNATURE Albert H. Hoppe	
25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	

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 *J. Wm. D. Embler*.....

Licensed Embalmer No. *3653*.....

P. O. Address *St. Louis, Mo.*.....

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.