

THE DIVISION OF HEALTH OF MISSOURI  
FILED APR 15 1957 STANDARD CERTIFICATE OF DEATH

State File No. **11695**  
Registrar's No. **401**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Koch, Mo</b>		c. CITY OR TOWN <b>ST LOUIS 2719</b>	
c. LENGTH OF STAY (in this place) <b>3 days</b>		d. Is Residence within limits of city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>29 Robert Koch Hosp</b>		e. STREET ADDRESS (If rural, give location) <b>21 4803 CHESTNUT ST</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>GUS</b> b. (Middle) _____ c. (Last) <b>STANCOFF</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>FEB 7 1957</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>unk</b>		8. DATE OF BIRTH <b>10/28/82</b>	
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nat. Carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Europe?</b>		12. CITIZEN OF WHAT COUNTRY? <b>unk</b>	
13a. FATHER'S NAME <b>CHRIST</b>		13b. MOTHER'S MAIDEN NAME <b>VALYKA</b>	
14. NAME OF HUSBAND OR WIFE <b>unk</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>447-05-2545</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>HOSPITAL RECORD, KOCH HOSP.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Meningitis</b>  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. <b>Mutiple Abscesses of liver diabetes with Coma</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>260X</b>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>Feb 5, 1957</b> , to <b>Feb 7, 1957</b> , that I last saw the deceased alive on <b>Feb 7, 1957</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>Frank Cohen MD</b>		23b. ADDRESS <b>Koch Mo</b>	
23c. DATE SIGNED <b>2-7-57</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
24b. DATE <b>2-13-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Morrell Brothers, 4212 St. Louis, Ave.</b>	
DATE REC'D BY LOCAL REG. <b>2-12-57</b>		REGISTRAR'S SIGNATURE <b>Herbert B. Dinkins</b>	

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 *G. W. Wilkinson*

Licensed Embalmer No. *3571*

P. O. Address *A. L. Smith*

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.