

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38790

FILED OCT 21 1957

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2492

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Affton</u>		c. CITY OR TOWN <u>ST. LOUIS</u> <u>4819</u> <u>0470</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MILLER NURSING HOME</u>		d. STREET ADDRESS (If outside, give location) <u>8149 GRAVOIS</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>LULU STOCKINGER</u>			4. DATE OF DEATH Month Day Year <u>OCT. 7 1957</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 13 1869</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIDOW</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13. FATHER'S NAME <u>ROBERT RISSE</u>	13b. MOTHER'S MAIDEN NAME <u>ELIZABETH CAWEIN</u>	14. NAME OF HUSBAND OR WIFE <u>FRED STOCKINGER (DEC'D)</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>OTTO RISSE</u> Address <u>3811 S. GRAND</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Parkinsonism</u>		<u>5 yrs</u>
	DUE TO (c) <u>arteriosclerotic heart disease</u>		<u>5 yrs?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>4/10/52</u> to <u>10/7/57</u> and last saw her/him alive on <u>10/7/57</u> Death occurred at <u>7 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>P. M. Green M.D.</u>	22b. ADDRESS <u>3402 California St. Louis</u>	22c. DATE SIGNED <u>10/7/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>OCT 9 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>
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24. FUNERAL DIRECTOR <u>Thomas Lutz 2906 Seneca</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Romke M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

4000
4

after 30 days. *Quarantine*
PR 2-3860

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 *Samuel C. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Harris*

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.