

Health,
Welfare
Public
Service

STANDARD CERTIFICATE OF DEATH

3579

STATE FILE NUMBER

FILED FEB 14 1958

318

1003

Registrar's No. 1267

Registration District No.

Primary Registration District No.

300

1-57

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSP. #1.</u>		Length of stay in lb <u>#1.</u>	d. STREET ADDRESS <u>12670 1504 Branch</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>NORMAN</u> Last <u>SCOVEL</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1912</u>	9. AGE (In years last birthday) <u>45</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>De Moines, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Frank Scovel</u>		13b. MOTHER'S MAIDEN NAME <u>Evelyn James</u>		14. NAME OF HUSBAND OR WIFE <u>Gertrude Scovel</u>	
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.		17. INFORMANT Address <u>Gertrude Scovel 1504 Branch</u>	
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>Subacute bacterial endocarditis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>430.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>rheumatic heart disease, congestive failure</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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	
21. I attended the deceased from <u>2/3/58</u> to <u>2/1/58</u> and last saw her alive on <u>2/1/58</u> Death occurred at <u>6:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Leroy A. Ortmejer M.D.</u> (Degree or title)			22b. ADDRESS <u>1515 LAFAYETTE AVE.</u>		22c. DATE SIGNED <u>2/1/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2/4/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, County, Mo.</u>
24. FUNERAL DIRECTOR <u>Schumacher's 3013 Meramec St.</u>			25. DATE RECD. BY LOCAL REG. <u>FEB 3 58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, Coroner, etc. must use only standard nomenclature in item 18. No symptoms with etiological All diseases in Part I must be causally related.

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 *Jack Haepp*

Licensed Embalmer No. *4746*

P. O. Address *St. Louis*

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.