

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 19 1958

58-012387
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2485**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis		c. CITY OR TOWN St. Ann	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 39 Cardinal Glennon Hosp 4 Da		d. STREET ADDRESS (If outside, give location) 270 3030 Belle Cote	
3. NAME OF DECEASED (Type or print) First Matthew Middle A. Last Terbrock		4. DATE OF DEATH Feb 28, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 31 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) #####		11. BIRTHPLACE (City and state or country) St. Louis Mo.	
13. FATHER'S NAME August Terbrock		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		14. MOTHER'S MAIDEN NAME Marcia Stumpf	
16. SOCIAL SECURITY NO. None		17. INFORMANT August Terbrock 3030 Belle Cote	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Visceral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Thrombocytopenia Purpura DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 296x			INTERVAL BETWEEN ONSET AND DEATH 5 days
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. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from 23 Feb 58 to 28 Feb 58 and last saw her/him alive on 28 Feb 58 . Death occurred at 6:43 am 28 Feb 58 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Lawrence D. Danahoe, MD (Degree or title)		22b. ADDRESS 950 Francis Place, Clayton	
22c. DATE SIGNED 28 Feb 58			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3/3/58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.		25. DATE RECD. BY LOCAL REG. MAR 1 58	26. REGISTRAR'S SIGNATURE Paul Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Sheldon Collier*

Licensed Embalmer No. *33*

P. O. Address *St. Ann*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.