

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-047236

STATE FILE NUMBER

11844

FILED JAN 19 1959

Registration District No.

318

Primary Registration District No.

1003

Registration District No.

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Anns 423X</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
f. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Mo. Baptist Hospital</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>27 3331 Chaucer</i>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <i>Steven Cordes</i>	4. DATE OF DEATH Month Day Year <i>December 8, 1958</i>
--	---

5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-8-58</i>	9. AGE (In years Just birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <i>5</i>
-----------------------	----------------------------------	---	------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
---	-----------------------------------	--	---

13a. FATHER'S NAME <i>Luke John Cordes</i>	13b. MOTHER'S MAIDEN NAME <i>Margaret Ann Horenkamp</i>	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no.</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Luke Cordes</i> Address <i>St. Anns, Mo. 3331 Chaucer.</i> <i>Margaret Cordes</i>
---	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anencephaly</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____	750X	
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>

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 Month, Day, Year a.m. p.m.	
---	--

20d. INJURY OCCURRED WHILE AT WORK <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
--	--	---

21. I attended the deceased from <i>12-8-58</i> to <i>12-8-58</i> and last saw him alive on <i>12-8-58</i> Death occurred at <i>2:00 P. m</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>George Austey M.D.</i>	22b. ADDRESS <i>4660 Maryland Ave</i>	22c. DATE SIGNED <i>12-9-58</i>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL DEC. 10, 1958</i>	23b. DATE <i>DEC. 10, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART CEM.</i>	23d. LOCATION (City, town, or county) (State) <i>FLORISSANT, MO.</i>
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR <i>M. J. CROGHAN</i> ADDRESS <i>831 E. BIG BEND WEBSTER GROVES 19</i>	25. DATE RECD. BY LOCAL REG. <i>DEC 9 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>
--	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Signed
Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.