Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-003502
STATE FILE NUMBER 128

JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [X] No [ ]

c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hos p #1 — Length of stay in 1b

d. STREET ADDRESS (If outside, give location) 100 S. Broadway — Reside on Farm Yes [X] No [ ]

3. NAME OF DECEASED (Type or print) First Leo Middle Last Shoreck

4. DATE OF DEATH Month Jan Day 4 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 1-27-1900

9. AGE (In years last birthday) 58 — 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) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (City and state or country) St. Jacob, Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Shoreck

13b. MOTHER'S MAIDEN NAME Rhoda Howard

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. # 1

16. SOCIAL SECURITY NO. ?

17. INFORMANT Olivia Shoreck, Address 3926 Castelmann

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chronic Lung Disease (Severe)

DUE TO (c) Emphysema - Bronchitis (chronic)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 502.0

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 12-27-58, to 1-4-59 and last saw her/him alive on 1-4-59
Death occurred at 12:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Arthur Smith M.D.

22b. ADDRESS 1515 Lafayette Ave.

22c. DATE SIGNED 1-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1-6-1959

23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette Ave.

25. DATE RECD. BY LOCAL REG. JAN 6 '59

26. REGISTRAR'S SIGNATURE J Earl Smith M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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 not embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....James R. Chapman.....

Licensed Embalmer No. ....4550....

P. O. Address ....St. Louis, Mo....

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.