THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007276
STATE FILE NUMBER

FILED MAR 9 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1500

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis
b. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Clayton 4452 — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Cardinal Glennon Hosp. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 619 Westwood Dr. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
RICHARD	T.	JOCHENS	Feb.	11	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		Dec. 23, 1958	0	1	18		

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)	12. CITIZEN OF WHAT COUNTRY?
None	None	St. Louis, Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Richard T. Jochens	Barbara K. Lovell	--------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	None	Richard T. Jochens	619 Westwood Dr.

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hydrocephalus congenital

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

DUE TO (b) congenital

DUE TO (c) 752.X

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)

Operation - cardiac arrest temporarily operation - with cardiac arrest

19. WAS AUTOPSY PERFORMED? YES ☒ 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 1-11-59, to 2-11-59 and last saw her him alive on 2-11-59

Death occurred at 7:35 A.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Frank A. Palazzo (Degree or title) M.D. Frank A. Palazzo M.D.

22b. ADDRESS 4161 Lindell 4161 Lindell Blvd

22c. DATE SIGNED 2-12-59

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

23b. DATE Feb. 12, 1959

23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery

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

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG. FEB 12 '59

26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 4533

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.