

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023596

STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1626

1. PLACE OF DEATH a. COUNTY ST LOUIS		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 TOWN CLAYTON		c. CITY OR TOWN OVERLAND 424X	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST L. COUNTY HOSP		d. STREET ADDRESS (If outside, give location) 9822 EAST BROOK DR	
Length of stay in 1b 2 DAYS		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) EMMA MAROTTE			4. DATE OF DEATH Month Day Year 6 15 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1887	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) RHINELAND MO		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME HENRY KOCH		13b. MOTHER'S MAIDEN NAME KATHERINE BRUENLING		14. NAME OF HUSBAND OR WIFE EDWARD MAROTTE	
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 Ira Childers 9822 EAST BROOK DR OVERLAND	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis due to			INTERVAL BETWEEN ONSET AND DEATH 6/13/59
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerosis		
	DUE TO (c) Bronchopneumonia		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. Month, Day, Year			

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 6-13-1959 to 6-15-1959 and last saw her alive on 6-15-1959 Death occurred at 9:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Angelo A. Speno M.D.	22b. ADDRESS 601 S. BRENTWOOD BLVD.	22c. DATE SIGNED 6/16/59.
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23a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	23b. DATE JUNE 16, 1959	23c. NAME OF CEMETERY OR CREMATORY LOCAL	23d. LOCATION (City, town, or county) (State) WATERLOO ILL
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24. FUNERAL DIRECTOR Emil Quersheim	ADDRESS WATERLOO ILL	25. DATE RECD. BY LOCAL REG. 6-16-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Frank Prokop*

Licensed Embalmer No. *4356*
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.