

**FEDERAL BUREAU OF INVESTIGATION**

**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-004118**

**FILED VS JAN 29 1960**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 604**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>Addieville</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>Rural Route # 1</b>	

3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>H.</b> Last <b>STORCK</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>15</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1916</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Okawville, Illinois.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>August Storck</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Koester</b>	14. NAME OF HUSBAND OR WIFE <b>Leona Storck</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>346-14-2306</b>	17. INFORMANT Address <b>Leona Storck, Addieville, Illinois.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b>		<b>2-3 HOURS</b>
DUE TO (b) <b>THROMBOSIS OF PELVIC VEINS, ETIOLOGY UNKNOWN</b>		<b>? 2 MONTHS</b>
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>RHEUMATIC HEART DISEASE WITH CONGESTIVE HEART FAILURE BRONCHOPNEUMONIA</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from **JAN. 4, 1960** to **JAN. 15, 1960** and last saw her/him alive on **JAN. 15, 1960**  
Death occurred at **4:40 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>C.D. Vermillion, M.D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>1/16/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/19/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Lutheran Cemetery</b>	23d. LOCATION (City, town, or county) <b>Okawville, Illinois.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JAN 18 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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ENDED  
 DOCUMENT  
 Funeral Director  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lawrence A. Gerling

Licensed Embalmer No. 4979

P. O. Address St. Louis, Mo.

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