

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-012007

STATE FILE NUMBER

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 829

FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, MO</u>		Length of stay in lb <u>25 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Koch Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>360 Wyoming</u>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>-</u> Last <u>LEO</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>24</u> - Year <u>61</u>	

5. SEX <u>Fem</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-21-81</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	IF UNDER 24 HR Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nil</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	

13a. FATHER'S NAME <u>Michael TREINEN</u>	13b. MOTHER'S MAIDEN NAME <u>DINAH ??</u>	14. NAME OF HUSBAND OR WIFE <u>LOUIS LEO (Deceased)</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>??</u>	17. INFORMANT <u>Records at Koch</u> Address
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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: IMMEDIATE CAUSE (a) <u>Tras. Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>		<u>??</u>
DUE TO (c) <u>Diabetes Mellitus 260XF</u>		<u>??</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RT. I.T. fx. Chronic Brain Syndrome</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Pl fell at home</u>
20c. TIME OF INJURY Hour <u>11:45</u> a.m. p.m. <u>P.M.</u> Month, Day, Year <u>Feb 1961</u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, MO</u> COUNTY <u>MO</u> STATE
21. I attended the deceased from <u>3-28-61</u> to <u>3-24-61</u> and last saw her alive on <u>3-24-61</u> . Death occurred at <u>11:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>Hank S. Russell, M.D.</u> (Degree or title)	22b. ADDRESS <u>Koch Hosp, Koch MO</u>	22c. DATE SIGNED <u>12/5/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW ST. MARCUS</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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24. FUNERAL DIRECTOR <u>SCHUMACHER'S 3013 MERAMEC</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>3-27-61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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DATE AMENDED

INSIDE OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Jack Haepp

Licensed Embalmer No. 4746

P. O. Address St. Louis

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.