

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

-61-019381

STATE FILE NUMBER

AMENDED

Registration District No. FILED JUN 8 1961 Primary Registration District No. Registrar's No. 5043

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jefferson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b <u>4 days</u>	c. CITY OR TOWN <u>DeSoto</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>804 So. 3rd Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>W.</u> Last <u>PROKOPF</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-1883</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Siper. Commercial Fert. Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armour and Co.</u>	11. BIRTHPLACE (City and state or country) <u>Frumet Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Frank Prokopf</u>		13b. MOTHER'S MAIDEN NAME <u>Johanna Guenther</u>		14. NAME OF HUSBAND OR WIFE <u>Mamie Prokopf</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			17. INFORMANT Address <u>Mamie Prokopf De Soto Mo.</u>			
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>CONGESTIVE HEART FAILURE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 YEARS</u>	
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					<u>1 1/2 YEARS</u>	
DUE TO (c) <u>420.0</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>URINARY TRACT INFECTION</u>				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		
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	COUNTY	STATE	
21. I attended the deceased from <u>MAY 24, 1961</u> to <u>MAY 28, 1961</u> and last saw her alive on <u>MAY 28, 1961</u> Death occurred at <u>8:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>C. Vermillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>5/29/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6-1-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) (State) <u>De Soto Mo.</u>			
24. FUNERAL DIRECTOR <u>Robins</u>		ADDRESS <u>E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 29 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>		

STATEMENT BY LICENSED EMBALMER

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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 Trokoff*

Licensed Embalmer No. 4356

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.