SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-019953
STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1279

FILED MAY 22 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Unincorporated — Length of stay in 1b: 1½ years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Evergreens Conval. Home — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Bel-Nor — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 8026 NaturalBridge Avenue — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Minnie Middle: Last: Stoecker
4. DATE OF DEATH Month: May Day: 4 Year: 1961
5. SEX: female
6. COLOR OR RACE: white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-23-1879
9. AGE (last birthday): 81 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Henry Schmidt
13b. MOTHER'S MAIDEN NAME: Louise Brune
14. NAME OF HUSBAND OR WIFE: Albert Stoecker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Albert Stoecker, Address: 8026 Natural Bridge Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) TERMINAL PNEMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
BRAIN SYNDROME
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

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 March 1961, to May 1961 and last saw her alive on April 20 '61
Death occurred at 10 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C. L. Clark (Degree or title) MD
22b. ADDRESS RT #1 Box 723 New Ballas Rd.
22c. DATE SIGNED 5/5/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: May 8, 1961
23c. NAME OF CEMETERY OR CREMATORY: OakGrove Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, County, Missouri

24. FUNERAL DIRECTOR ADDRESS: Math Hermann & Son, Inc., 2161 E. Fair Ave
25. DATE RECD. BY LOCAL REG.: 5-5-61
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — 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 me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Clement McNeary

Signature of Student Embalmer

Licensed Embalmer No. 3732

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.