

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035215

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 2517

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Koch</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>St. Louis</u>		Length of stay in 1b <u>74 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2937 Lafayette</u>
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>MARY</u> Last <u>Chamber</u>			4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>61</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</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>12/2/85</u>
9. AGE (last birthday) <u>75 yrs</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>Ind.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Frank Truckey</u>		13b. MOTHER'S MAIDEN NAME <u>Mary</u>	14. NAME OF HUSBAND OR WIFE <u>THOMAS</u>
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. <u>-</u>	17. INFORMANT <u>R. Koch Hospital's record.</u> Address
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>PULMONARY EMBOLISM</u> DUE TO (b) <u>DEBILITY + MALNUTRITION</u> DUE TO (c) <u>CEREBRAL CONTUSION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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. <u>904.9-45</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>Fracture of R. parietal at 5.12.61 and alcohol intoxication</u>	
20c. TIME OF INJURY Hour <u>5</u> Month, Day, Year <u>12-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>?</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>6-21-1961</u> to <u>9-2-1961</u> and last saw her/him alive on <u>9-2-61</u> Death occurred at <u>3:55 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>Bernard Luedman M.D.</u>		22b. ADDRESS <u>Koch Hosp, Koch, Mo.</u>	22c. DATE SIGNED <u>9-2-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/8/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
24. FUNERAL DIRECTOR <u>E.J. Schnur 3125 Lafayette Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>

STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Joseph B. Volmer

Licensed Embalmer No. 41014

P. O. Address 3125 Lehigh

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.