

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

9518 -61-039271  
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9518

**FILED OCT 26 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS,</u>		c. CITY OR TOWN <u>ST LOUIS,</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FAITH HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4627 SAN FRANCISCO AVE</u>	

3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>E.</u> Last <u>STOREY</u>			4. DATE OF DEATH <u>OCT, 13, 1961</u> Month Day Year		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/01</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>ST LOUIS MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN G. STOREY</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA RONAN</u>		14. NAME OF HUSBAND OR WIFE	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes, give war or dates of service) <u>NO</u>	17. INFORMANT <u>MARGARET SOWERS 4627 SANFRANCISCO</u>
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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>Acute Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
DUE TO (b) <u>Acute Cardiac Decomp</u>		<u>1 week</u>
DUE TO (c) <u>metastatic carcinoma</u>		<u>1 year</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cochlear - Primary Carcinoma of Lung</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 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>161X</u>
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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
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21. I attended the deceased from 1958 to 10-13-61 and last saw her alive on 10-13-61  
Death occurred at 9:15 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>3400 N. KINGS HIGHWAY No 15</u>	22c. DATE SIGNED <u>10/14/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/16/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS MISSOURI</u>
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24. FUNERAL DIRECTOR <u>STROOT - CARROLL 4600 NAT'L BRIDGE</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 16 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Casoppo  
3400 no number  
for 1-6667  
10 am

**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

*M W Rueter*

Licensed Embalmer No.

*4865*

P. O. Address

*St Louis, Mo*

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.