

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

11197

-61-042870

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

FILED DEC 12 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

HOW NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> COUNTY <b>Gallatin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Shawneetown</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>REGINA Marlene SCHRACK</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 28 1961</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/1946</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>15</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) <b>Shawneetown, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>George Schrack</b>		13b. MOTHER'S MAIDEN NAME <b>Aileen Oldham</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Aileen Winters, Shawneetown, Ill.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>			INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CORRECTION OF PULMONIC STENOSIS</b>			<b>2 HOURS</b>
DUE TO (c) <b>CONGENITAL HEART DISEASE WITH PULMONIC STENOSIS</b>			<b>15 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>754.7</b>			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
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 <b>NOVEMBER 5, 1961</b> to <b>NOV. 28, 1961</b> and last saw her/him alive on <b>NOVEMBER 28, 1961</b> Death occurred at <b>2:35 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>F. R. BRADLEY, M. D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>11/29/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-1-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Goldhill Twp., Ill.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 1 1961</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>

**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

*Howey Kahle*

Licensed Embalmer No. 4596

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.