

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-042934

STATE FILE NUMBER

318

1003

11391

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4938 Robert		d. STREET ADDRESS (If outside, give location) 4938 Robert	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Anna Stratton			4. DATE OF DEATH Month Day Year 12 4 61			
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5. SEX F	6. COLOR OR RACE. W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/2/1883	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer retired	10b. KIND OF BUSINESS OR INDUSTRY Lweis Howe	11. BIRTHPLACE (City and state or country) St. Louis	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Joseph Galen	13b. MOTHER'S MAIDEN NAME Mary Meyer	14. NAME OF HUSBAND OR WIFE George (deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Address Valeria Tentschert 4938 Robert
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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>CARDIAC INSUFFICIENCY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROTIC HEART.</u>	
	DUE TO (c) <u>420.0 DISEASE.</u>	

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. <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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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 <u>MARCH 24, 1956</u> to <u>DEC. 4, 1961</u> and last saw her/him alive on <u>DEC. 2, 1961</u> Death occurred at <u>12:25 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Robert E Koch, M.D.</u> (Degree or title)	22b. ADDRESS <u>35 N. Central</u>	22c. DATE SIGNED <u>12.5.61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>12/7/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stes Peter &amp; Paul</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Schumacher 3013 Meramec</u>	25. DATE RECD. BY LOCAL REG. <u>DEC 7 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Form 25 1/27/60  
Rec'd from coast  
Nance

**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 Jack Haept  
Licensed Embalmer No. 4746

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.