

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043236

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3333

AMENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b> Length of stay in 1b <b>5 Hrs.</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>University City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>6315 Bartmer Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Barnetta</b> Middle <b>A.</b> Last <b>Storch</b>			4. DATE OF DEATH Month <b>11-</b> Day <b>23-</b> Year <b>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>9-12-1893</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Lewis Storch</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Zimmerman</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>Angelina Frank 6315 Bartmer Ave.</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>Acute hemorrhagic shock</b> DUE TO (b) <b>Massive hemorrhage from gastric carcinoma</b> DUE TO (c) <b></b> 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) <b>Marked arteriosclerotic heart disease</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 checked="" type="checkbox"/> NO <input 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 <b></b> Month, Day, Year <b></b>		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.) <b>1106 Pm</b>		20f. CITY, TOWN, OR LOCATION <b>6:30pm</b>		COUNTY STATE		
21. I attended the deceased from <b>11-23-1961</b> to <b>11-23-1961</b> and last saw her/him alive on <b>11-23-1961</b> Death occurred at <b>6:30 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>Lucient J. Friedrich MD</b>			22b. ADDRESS <b>601 S. Brentwood Clayton Mo</b>		22c. DATE SIGNED <b>11/24/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 27, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chesterfield, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 9450 Olive St. Road</b>			25. DATE RECD. BY LOCAL REG. <b>11-24-61</b>		26. REGISTRAR'S SIGNATURE <b>J. C. Murphy MD</b>	

DATE AMENDED  
INSTEAD OF  
ITEM NO.  
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 R. W. Stovesund

Licensed Embalmer No. 4007

P. O. Address \_\_\_\_\_

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.