

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047414

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 377

Primary Registration District No. 500

Registrar's No. 3363

STATE FILE NUMBER

AMENDED

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Dellwood		Length of stay in 1b 2 1/2 years	c. CITY OR TOWN Dellwood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1660 Maldon Ln.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1660 Maldon Ln Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EMMETT Middle LEE Last STORCK			4. DATE OF DEATH Month November Day 26 Year 1961			
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1903	9. AGE (last birthday) 57 years IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor	10b. KIND OF BUSINESS OR INDUSTRY Paint Store	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME Hugo Storck	13b. MOTHER'S MAIDEN NAME Mabel A. Lee	14. NAME OF HUSBAND OR WIFE Adele Storck
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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 Adele Storck - 1660 Maldon Lane
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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) METASTATIC CARCINOMA, SQUAMOUS CELL		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CARCINOMA MAIN BRONCHUS RIGHT LUNG	
	DUE TO (c)	

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 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 9/17/60 to 11/26/61 and last saw him alive on 11/25/61.
Death occurred at 4:45 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Carl W. Lawrence, M.D.	22b. ADDRESS 6000 WEST FLORISSANT	22c. DATE SIGNED 11/27/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Nov. 30, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
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24. FUNERAL DIRECTOR BUCHHOLZ MORTUARY-5967 West Florissant Ave	25. DATE RECD. BY LOCAL REG. 11-27-61	26. REGISTRAR'S SIGNATURE [Signature]
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 Ralph C. Leinders

Licensed Embalmer No. 4275

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.