

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007793

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1742** STATE FILE NUMBER

AMENDED

FILED FEB 23 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 Mo.	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5000 S. Broadway Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SOPHIE BODE			4. DATE OF DEATH Month Day Year Feb. 11, 1962			
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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 10-6-1871	9. AGE (last birthday) 90	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) St. Louis	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME August Schirr	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Otto J. Bode
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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) None	16. SOCIAL SECURITY NO. None	17. INFORMANT Walter O. Bode 16 Algonquin Wood Address
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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) Pelvic abscess due to perforation of colon Perforation of colonic diverticulum DUE TO (b) Perforation of colonic diverticulum DUE TO (c) colonic diverticulitis		INTERVAL BETWEEN ONSET AND DEATH three days 2 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. cerebral arteriosclerosis 2. nephrosclerosis		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 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.) 5721
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	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 8/1/42 to 2/11/62 and last saw ^{her} _{him} alive on 2/11 at 2:45 PM Death occurred at 3:10 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) David M. Skilling, Jr., M.D.	22b. ADDRESS 18 So. Kingshighway (8)	22c. DATE SIGNED 2/12/62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 2-12-1962	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
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24. FUNERAL DIRECTOR Parker-Aldrich Webster Groves Mo.	25. DATE RECD. BY LOCAL REG. FEB 12 1962	REGISTRAR'S SIGNATURE Roald Smith, M.D.
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 *No embalming* Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Whiter Grove*

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.