

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-048914

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 3174

Primary Registration District No. 547

Registrar's No. 3621

FILED JAN 10 1962

VS 300
Rev. 4/59

1 4005
2 8040
3 2
4 1
5 2
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7 1
8 2
9 4200
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11
12 46-0
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis		a. STATE California COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights,		c. CITY OR TOWN Santa Monica	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b 11 days		d. STREET ADDRESS (If outside, give location) 500 California Ave.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE CHEROT BOCK			4. DATE OF DEATH Month Day Year December 12, 1962
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar. 28, 1872
9. AGE (last birthday) 90		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sales		10b. KIND OF BUSINESS OR INDUSTRY cosmetic industry	11. BIRTHPLACE (City and state or country) Green Bay, Wisconsin
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Leonce Cherot	
13b. MOTHER'S MAIDEN NAME ---		14. NAME OF HUSBAND OR WIFE ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Webster Mrs. Raymond Gorman, 375 South Elm, Groves
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____			
DUE TO (c) Senility			
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
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 <u>10-30-62</u> to <u>12-12-62</u> and last saw her alive on <u>12-12-62</u> Death occurred at <u>7⁵⁰ AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. J. Vetter</i>		(Degree or title)	22b. ADDRESS 8787 Big Bend
22c. DATE SIGNED 12/12/62		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Dec. 14, 1962	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
24. FUNERAL DIRECTOR M. J. Croghan, 7825 Big Bend Blvd.		25. DATE RECD. BY LOCAL REG. 12-12-62	26. REGISTRAR'S SIGNATURE <i>John B. Murphy</i>
Webster Groves 19, Missouri (Licensed Embalmer's Statement on Reverse Side)			

Dr. Valerian
MO - 1 - 4868

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

Yau M. Seymour

Licensed Embalmer No. 4343

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.