

No. 2
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 21 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3576

State File No. _____

Registration District No. 377

Primary Registration District No. 3064

Registrar's No. 175

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Ferguson 21
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 714 No. Florissant 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Ferguson 21
(If outside city or town limits, write "RURAL")

(d) Street No. 714 No. Florissant 2
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JERRY LIEGH SCHROCK

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar. 28 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

6 9 17 hr. min.

9. Birthplace Cuba Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Jewel Schrock

13. Birthplace Green Street Ark
(City, town, or county) (State or foreign country)

14. Maiden name Rosemary Mumment

15. Birthplace Overland Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Rosemary Chappelle

(b) Address 714 No. Florissant

17. (a) Cremation (b) Date thereof Jan 17 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walhalla Crematory

18. (a) Signature of funeral director Walter Center Mortuary

(b) Address 4024 Lindell Blvd

19. (a) 1-16-48 (b) Geulay Hay MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15
year 1948 hour 11 minute 15A.M.

21. I hereby certify that I attended the deceased from October, 1947, to January, 1948;
that I last saw him alive on January 15, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration _____

Due to _____

Due to _____

Other conditions Spastic Paralysis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

ADDIT
SUPPL
QUEST

Underline the cause of death which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B.B. Hagen DC (M.D. or other) _____
Address 9701 F. Louisburg Rd Date signed 1-16-48

(Licensed Embalmer's Statement on Reverse Side) St. Louis 21

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 2 1948

Method He 315 2012

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed *Ronald Yahrke*.....

Licensed Embalmer No. *3917*.....

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 this body is not embalmed, fact should be so stated above.

State File No. Feb
Registrar's No. 125

Registration District No. 317 Primary Registration District No. 3064

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Ferguson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Jerry L. Schrock
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color of race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased March 28
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) mo

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 1944 Day _____ Year _____ month _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Bronchopneumonia

Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 107
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature B. B. Hagen (M.D. or other) _____
Address 2201 Flouissant Rd Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

1948
S-3576