

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43354

FILED JAN 10 1952

State File No. 11228

318

1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>3 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Infirmery</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u> b. (Middle) _____ c. (Last) <u>Stocksick</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-17-51</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>		8. DATE OF BIRTH <u>about 85</u>	
9. AGE (in years last birthday) _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 MRS. Hours _____ Mins. _____		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
10a. USUAL OCCUPATION (Give kind of work during most of working life, when if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>		13. FATHER'S NAME <u>John Schier</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Fred Stocksick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records City Infirmery, 5800 Arsenal St.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arteriosclerosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>334X</u>					
22. I hereby certify that I attended the deceased from _____, 19____, to <u>12-17-51</u> , 19____, that I last saw the deceased alive on <u>12-17-51</u> , 19____, and that death occurred at <u>1:10 p.m.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>George M. Januska M.D.</u>		(Degree or title)		23b. ADDRESS <u>5800 Arsenal</u>		23c. DATE SIGNED <u>12-17-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-20-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, MO</u>	
DATE REC'D BY LOCAL REG. <u>DEC 19 1951</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>McLaughlin 2301 DePuyette</u>			

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

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.

*Not Embalmed*

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*T. G. Harris*

Licensed Embalmer No. *3384*

P. O. Address. *2301 Lafayette*

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.