S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36892

State File No.

FILED NOV 14 1952

BIRTH NO. 56692 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9540

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~St. Louis~~
d. STREET ADDRESS (If rural, give location): 7726 Delmar Bl.

4376
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3. NAME OF DECEASED (Type or Print)
a. (First): ~~[illegible]~~
b. (Middle): ARCHIE
c. (Last): STORZ

4. DATE OF DEATH (Month) (Day) (Year): October 14, 1952

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Aug. 19 1952
9. AGE (In years last birthday): If under 1 year: Months 1, Days 25; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): St. Louis
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Lester Storz
13b. MOTHER'S MAIDEN NAME: Pauline Dowell
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Lester Storz
ADDRESS: 7726 Delmar

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 493X

22. *I hereby certify that I attended the deceased from* 8-19-52, 19___, *to* 10-14-52, 19___, *that I last saw the deceased alive on* 10-14-52, 19___, *and that death occurred at* 2:25P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Homer H. Hanson, M.D.
23b. ADDRESS: 1515 Lafayette Avenue
23c. DATE SIGNED: 10-15-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/16/1952
24c. NAME OF CEMETERY OR CREMATORY: St. Matthews
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: OCT 16 1952
REGISTRAR'S SIGNATURE: Earl Smith MD
MB
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS**: McLAUGHLIN FUNERAL HOME, INC.

(Licensed Embalmer's Statement on Reverse Side)

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 not embalmed, Student Embalmer No. ....., working under my personal supervision.

Student .....
Student Embalmer

Signed W. G. Farris

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.