

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35230

State File No. \_\_\_\_\_

8776

FILED OCT 24 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		e. STREET ADDRESS (If rural, give location) <u>15 5009 South Grand Blvd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Charl</u> b. (Middle) <u>Joseph</u> c. (Last) <u>Torrence</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>October 6, 1955</u>		
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5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>February 5, 1893</u>		9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
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13a. FATHER'S NAME <u>Frederick A. Torrence</u>			13b. MOTHER'S MAIDEN NAME <u>Frances Prevot</u>			14. NAME OF HUSBAND OR WIFE <u>Ida B. Torrence</u>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.#1</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ida B. Torrence 5009 So. Grand Blvd</u>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Cerebral thrombosis</u>						<u>4 days</u>	
		ANTECEDENT CAUSES							
		<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) <u>Arteriosclerosis</u></p> <p>DUE TO (c)</p>						<u>2 years</u>	
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>332x</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 1, 1950, to Oct. 6, 1955, that I last saw the deceased alive on Oct. 6, 1955 and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>A. W. Peters</u> M.D.		23b. ADDRESS <u>4145 a S. Grand Blvd.</u>		23c. DATE SIGNED <u>10/7/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 10, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
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DATE REC'D BY LOCAL REG. <u>OCT 7 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hoffmeister Colonial Mortuary 6464 Chippewa St. St. Louis 9, Mo.</u>	
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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..

Student.....  
Signature of Student Embalmer

Signed *Harry J. Shamack*  
Licensed Embalmer No. *2679*

P. O. Address *277 4th Ave*

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.