

S. No. 300
Ev. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14437

FILED MAY 1 - 1957

State File No. 3682
Registrar's No.

| | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--|
| 1. 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 death) a. STATE Missouri b. COUNTY St. Louis | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. LENGTH OF STAY (in this place) 12 days | | c. CITY OR TOWN Clayton | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Firmen Desloge Hosp. | | | | e. STREET ADDRESS 224 Topton Way | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Alvina b. (Middle) -- c. (Last) Baker | | | 4. DATE OF DEATH (Month) (Day) (Year) Apr. 16. 1957 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH May 26, 1893 | | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME Adolph M. Schilly | | 13b. MOTHER'S MAIDEN NAME Ann Zeller | | 14. NAME OF HUSBAND OR WIFE George E. Baker | | | | |
| 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. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Baker 224 Topton Way | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>FIBRO SARCOMA OF MEDIASTINUM WITH EXTENSION TO BOTH LUNGS</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) <u>164x</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>16 mo.</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>Condition demonstrated at Thorocatomy 1955</u> | | | | 20. AUTOPSY? / YES <input checked="" 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) | | 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 <u>April 14, 1956</u> , to <u>April 16, 1957</u> , that I last saw the deceased alive on <u>April 16, 1957</u> , and that death occurred at <u>10:55 a.m.</u> , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE (Name or title) <u>Max Stenboll MD</u> | | | | 23b. ADDRESS <u>512 Dover Place</u> | | 23c. DATE SIGNED <u>4-17-57</u> | | |
| 24a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>4/18/57</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u> | | 24d. LOCATION (City, town; or county) (State) <u>St. Louis Co. Mo.</u> | | |
| DATE REC'D BY LOCAL REG. <u>APR 17-57</u> | | REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stock Mortuaries 889 S. Brentwood Clayton</u> | | | | |

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

Dr. Max [unclear]

512 Karen Pl. FL 3-1706

Residence 6320 Forsyth P.H. 7-2883

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.....
Paul A. Wichter

Licensed Embalmer No: *4787*

P. O. Address *Shoreline*

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.