

FILED SEP 23 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8484**

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>			Length of stay in 1b <b>76 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>5474 Morganford Rd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IDA</b>				First <b>Middle</b> <b>Last</b> <b>F. STORCK</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>8</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Aug. 24, 1881</b>		9. AGE (In years last birthday) <b>76 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Franck</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Ponick</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Erwin Storck, 5209 Bates Street</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Fracture of Right Hip;</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (Mention given in Part I) (a) <b>Suffered with stroke by CVA operated by one of Dr. Balle and Morganford, about</b>							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>She fell at rear section of Bates and Morganford, about</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour <b>5:19</b> p. m. Month, Day, Year <b>9 6 57</b>		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>15 Street</b>			20e. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>			COUNTY <b>25</b> STATE
21. I attended the deceased from _____ to _____ and last saw <sup>body</sup> him alive on _____ Death occurred at <b>11:45 P</b> m on the day stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Joseph M. Smith, M.D.</b>			22b. ADDRESS <b>1300 Clark</b>			22c. DATE SIGNED <b>9/10/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9-12-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concordia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>SEP 10 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		

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 Deliv J. Kraspin

Licensed Embalmer No. 34

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.