

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36453

STATE FILE NUMBER

62

FILED OCT 16 1957

159

4249

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hillsboro</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Webster Groves</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Cedar Grove Nurs. Home</b>		Length of stay in lb <b>8-mo</b>	d. STREET ADDRESS (If outside, give location) <b>960 Briarton</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Fred</b> Middle <b>S</b> Last <b>Sturm</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>9</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1890</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Loy-Lange Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>190-05-2456A</b>	17. INFORMANT <b>Kenneth Sturm - Webster Groves, Mo.</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>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <b>3</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input 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.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <b>March 1957</b> to <b>Oct 9/1957</b> and last saw <sup>her</sup> him alive on <b>Oct 6, 1957</b> Death occurred at <b>9:30 P. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <b>John W. Daake M.D.</b>		22b. ADDRESS <b>3606 Gravois St. Louis, Mo.</b>	22c. DATE SIGNED <b>10-10-57</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct. 12, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>WACKER-HELDERLE-3634 Gravois Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>10-10-57</b>	26. DEATH REPORT SIGNATURE <b>John W. Daake M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

Health,  
Welfare  
Public  
Service

JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED

OCT 11 1957  
OCT 17 1957

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..... *Rose A. Wheeler* .....

Licensed Embalmer No. *21*

P. O. Address *St. Louis*

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.