

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3737

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1147**

300
1-57

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in lb 61 Yrs	d. STREET ADDRESS (If outside, give location) 3829 Indiana Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALVINA Middle G. Last VOLK		4. DATE OF DEATH Month Jan. Day 29, Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1896
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
10a. KIND OF BUSINESS OR INDUSTRY at home		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Victor Schreiner		13b. MOTHER'S MAIDEN NAME Mary Kraft	14. NAME OF HUSBAND OR WIFE Fred L. Volk
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. ---	17. INFORMANT Address Joseph L. Schreiner, 3829 Indiana Avenue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, Generalized abdominal Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Carcinoma ovary DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 175.0			INTERVAL BETWEEN ONSET AND DEATH 5 months 7-12 months
19. WAS AUTOPSY PERFORMED? 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 _____ 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 Death occurred at 8/26/57 to 1/29/58 and last saw her/him alive on 1/28/58 1:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert H. Pason M.D. (Degree or title)		22b. ADDRESS 4401 Hampton Ave	22c. DATE SIGNED 1/30/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Jan. 31, 1958	23c. NAME OF CEMETERY OR CREMATORY Old SS Peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave		25. DATE RECD. BY LOCAL REG. JAN 30 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

Doctor, coroner, etc. must use only standard manufacturers or return to: No symptoms with or without. All diseases in Part I must be causally related.

Dr. Elbert Gason
4401 Hampton

1:30 to 4 PM except Wed Sat

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 *Delia J. Krupin*

Licensed Embalmer No. *3497*

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.