

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003951  
STATE FILE NUMBER

JAN 28 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>City of St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch, Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis 223<sup>9</sup></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>Robert Koch Hosp. 164 days</b> Length of stay in lb		d. STREET ADDRESS <b>910 Julia</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edwin Joseph Dankel</b> First Middle Last		4. DATE OF DEATH <b>1-12-1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-13-1916</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug Clerk</b>		9b. AGE (In years last birthday) <b>42</b>	9c. 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)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10d. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joe Dankel</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Schwartz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Army</b> (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>490-12-1004</b>	
17. INFORMANT <b>Records of Robert Koch Hosp., Koch, Mo.</b> Address		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>Pulmonary tuberculosis</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>002X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>8-1-1958</b> to <b>1-12-1959</b> and last saw <b>her</b> alive on <b>1-12-59</b> Death occurred at <b>12:30</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Axel R. Groman, M.D.</b>		22b. ADDRESS <b>Robert Koch Hosp., Koch, Mo.</b>	
22c. DATE SIGNED <b>1/12/59</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE <b>JAN 15, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>JEFFERSON BRKS.</b>		23e. (State) <b>Mo</b>	
24. FUNERAL DIRECTOR <b>Thomas Luta 2906 Shavanois</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>1-14-59</b>	
26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>			

DISEASES IN PART I MUST BE CASUALLY RELATED. CORONER CANNOT CERTIFY TO A DEATH DUE TO NATURAL CAUSES. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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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 *Samuel C. White*.....

Licensed Embalmer No. *43*.....

P. O. Address *2906 E*.....

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