

JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042573

FILED VS NOV 19 1959

210297

STATE FILE NUMBER

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

UNRECORDED

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		c. CITY OR TOWN St Louis	
Length of stay in 1b		Inside Limits <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Hosp		d. STREET ADDRESS (If outside, give location) 2731 Accomac Street	
Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Diane Middle Marie Last Stockmann			4. DATE OF DEATH Month Nov Day 7 Year 1959		
---	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/22/59	9. AGE (last birthday) IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.
-------------------------	----------------------------------	---	-------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis Mo.	12. CITIZEN OF WHAT COUNTRY
--	-----------------------------------	---	-----------------------------

13a. FATHER'S NAME Herbert Stockmann	13b. MOTHER'S MAIDEN NAME Jane Bujnak	14. NAME OF HUSBAND OR WIFE None
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Herbert Stockmann 2731 Accomac St
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH Several hours
IMMEDIATE CAUSE (a) Acute Cardiac Distention		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Adrenogenital Syndrome	several days
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
277x			

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 _____ s.m. _____ p.m.	Month, Day, Year _____
---	------------------------

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 **10-22-59** to **11-7-59** and last saw her alive on **11-6-59**
Death occurred at **8:45 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John Flynn B. M.D. (Degree or title)	22b. ADDRESS 1715 So 39th St St Louis Mo	22c. DATE SIGNED 11-7-59
---	--	------------------------------------

23a. BURIAL, CREMATION, RECOVERY (Specify) Burial	23b. DATE 11/10/59	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St Louis County Mo
---	------------------------------	--	--

24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen	ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 9 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
--	---------	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Halley A. Jaeger Jr

Licensed Embalmer No. 4950

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.