

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004115

FILED VS FEB 10 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 985** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.				Length of stay in 1b 30 yrs. 4 mo 4 days		c. CITY OR TOWN St. Louis, Mo.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1242 S. Broadway				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNY Middle STOKER Last STOKER						4. DATE OF DEATH Month Jan. Day 20, Year 1960							
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10-14-87		9. AGE (last birthday) 72		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) formerly: housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jefferson County, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME George Stoker				13b. MOTHER'S MAIDEN NAME Martha (Ogle) Stoker				14. NAME OF HUSBAND OR WIFE Andrew Schott					
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 Hospital Records 5400 Arsenal							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pneumonia DUE TO (c) 493x										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Paranoid Schizophrenia										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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. 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 Sept. 16, 1929 to Jan. 20 1960 and last saw her ^{him} alive on Jan. 20, 1960 Death occurred at 12:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. A. F. Heusler, M.D.													
22a. SIGNATURE A F Heusler (Degree or title)						22b. ADDRESS 5400 Arsenal St.			22c. DATE SIGNED 1-21-60				
23a. BURIAL, CREMATION, REMOVAL (Specify) JAN 30 1960		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board				23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)					
24. FUNERAL DIRECTOR Rowland Mortuary Svc. 4104-06 Manchester				25. DATE RECD. BY LOCAL REG. JAN 28 1960		26. REGISTRAR'S SIGNATURE Neal Smith, M.D.							

(Licensed Embalmer's Statement on Reverse Side)

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
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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