

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024442

FILED VS. JUL 12 1960

318 Primary Registration District No. 1003 Registrar's No. 6680

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis City Hosp. # 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1518 - PICKER - ST.</u>
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>Louise</u> Last <u>DERKOSKI</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-1897</u>
9. AGE (last birthday) <u>62 YRS</u>		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) <u>CUSTODIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CITY-HOSPITAL #1.</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS - MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>ADAM - BUECHLER</u>	
13b. MOTHER'S MAIDEN NAME <u>ESTER - DAY</u>		14. NAME OF HUSBAND OR WIFE <u>FELIX - DERKOSKI (DECD.)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>494-01-6232A.</u>	17. INFORMANT <u>JOHN - DERKOSKI =</u> Address <u>318 NO. 63 RD. ST EAST - ST. LOUIS - ILL.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute brain syndrome</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr</u> <u>3 days</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Atrial fibrillation</u>			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 <u>6/27/60</u> to <u>6/30/60</u> and last saw her <u>alive</u> on <u>6/30/60</u> Death occurred at <u>2:05</u> <u>p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W Yates Trotter Jr. M.D.</u> (Degree or title)		22b. ADDRESS <u>1515 Lafayette Ave.</u>	22c. DATE SIGNED <u>6/30/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JULY-2-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>
24. FUNERAL DIRECTOR <u>Brockland Und.Co. 1827-HOGAN-ST</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>JUL 1 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mjb

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 Stanley H. Dixon

Licensed Embalmer No. 419

P. O. Address St. L.

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.