

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037086

ED VS OCT 17 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2826

STATE FILE NUMBER

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 (If outside corporate limits, give TOWNSHIP only) <b>Koch, Missouri</b>		Length of stay in 1b <b>189 days</b>		c. CITY OR TOWN <b>St. Louis</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 Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4542 Oregon</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elfie</b> Middle <b>E.</b> Last <b>Storz</b>				4. DATE OF DEATH Month <b>9</b> Day <b>22</b> Year <b>60</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-29-79</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nil</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>William Storz</b>			13b. MOTHER'S MAIDEN NAME <b>Barbara Schwartz</b>			14. NAME OF HUSBAND OR WIFE <b>Nil</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Medical Records, Koch Hospital</b>				
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	
IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b>							<b>Indefinite</b>	
DUE TO (b) <b>Chronic nutritional deficiency</b>								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Osteoporosis. Fracture of right hip; chronic brain syndrome; retrosternal nodular thyroid.</b>							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 checked="" 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.) <b>Fall at home.</b>					
20c. TIME OF INJURY Hour <b>2-26-60</b> a.m. p.m.	Month, Day, Year <b>2-26-60</b>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis, Missouri</b>		COUNTY STATE		
21. I attended the deceased from <b>3-18-60</b> to <b>9-22-60</b> and last saw <b>her</b> alive on <b>9-22-60</b> Death occurred at <b>6:40 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Harold E. Russell M.D.</b>				22b. ADDRESS <b>Robert Koch Hospital</b>		22c. DATE SIGNED <b>9-23-60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>9/26/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>				
24. FUNERAL DIRECTOR <b>Edward Fendler 5611 South Grand Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>9-26-60</b>		26. REGISTRAR'S SIGNATURE <b>John B. [Signature]</b>			

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 George W. Warratt

Licensed Embalmer No. 4799

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.