

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER **61-039270**

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10112**

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay, in 1b		c. CITY OR TOWN <b>St. Louis</b>		inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Little Flower Con. Home</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3817 Indiana Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MAYME</b> Middle Last <b>STOCKER</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>30</b> Year <b>1961</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1882</b>	9. AGE (last birthday) <b>79</b>	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) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Martin Cardiff</b>			13b. MOTHER'S MAIDEN NAME <b>Johanna Casey</b>		14. NAME OF HUSBAND OR WIFE <b>Late George C. Stocker</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>None</b>		17. INFORMANT Address <b>Georgia S. Weber 3817 Insiana Ave.</b>			
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>Pneumonia, hypotonia</b> DUE TO (b) <b>Multiple myeloma</b> DUE TO (c) <b>203X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 mo.</b>
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 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 <b>April 1955</b> to <b>Oct 30-4</b> and last saw her/him alive on <b>Oct 30-'61</b> Death occurred at <b>11:18 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Paul Taraschak MD</b>				22b. ADDRESS <b>5203 Chippewa</b>		22c. DATE SIGNED <b>10/31/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 2, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 31 1961</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

**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 R.W. Steward

Licensed Embalmer No. 4007

P. O. Address, St. Louis, Mo.

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.