

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE **318** Primary Registration District No. **1003** Registrar's No. **11031** STATE FILE NUMBER **-61-042937**

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Registration District No. **FILED DEC 1 1961**

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		Length of stay in 1b 2 weeks	c. CITY OR TOWN St. Louis 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. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6174 Lalite Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DONALD Middle D Last STROCK			4. DATE OF DEATH Month November Day 26 Year 1961		
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1891	9. AGE (last birthday) 67 years	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME Sam Bell Strock		13b. MOTHER'S MAIDEN NAME Clara Wolfe		14. NAME OF HUSBAND OR WIFE Mildred Strock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WWI			17. INFORMANT Address Mildred Strock - 6174 Lalite		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelocytic Leukemia		INTERVAL BETWEEN ONSET AND DEATH 3 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
DUE TO (c) 204.3		
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

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 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 August 1961 to Nov 26, 1961 and last saw him alive on Nov 25, 1961 Death occurred at 10 am on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) John B. Shapleigh M.D.	22b. ADDRESS 3720 Washington St. Louis, Mo.	22c. DATE SIGNED 11/27/61
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Nov. 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis Missouri		

24. FUNERAL DIRECTOR ADDRESS Buchholz Mortuary-5967 W. Florissant Ave	25. DATE RECD. BY LOCAL REG. NOV 27 1961	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
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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 Walter J. Burkholy
Licensed Embalmer No. 4551
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.