SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-047488
STATE FILE NUMBER

AMENDED

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 232

FILED DEC 26 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY Saline
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall — Length of stay in 1b 20 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Marshall State School & Hosp. — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 5391 Cote Brilliante — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Irvin Middle --- Last Schainker

4. DATE OF DEATH Month 22 Day Dec Year 61

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 6-29-1925
9. AGE (last birthday) 36 yrs. — 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) Patient
10b. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME David Schainker
13b. MOTHER'S MAIDEN NAME Lena Novack
14. NAME OF HUSBAND OR WIFE -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Records of Marshall

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Congenital Heart — 36 yr
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Mental retardation with convulsive disorder

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1955 to 22 Dec '61 and last saw him alive on 22 Dec 61
Death occurred at 12:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. Lee McCorkle MD
22b. ADDRESS Marshall Mo
22c. DATE SIGNED 22 Dec 61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 12-24-1961
23c. NAME OF CEMETERY OR CREMATORY —
23d. LOCATION (City, town, or county) (State) St Louis Mo

24. FUNERAL DIRECTOR ADDRESS BERGER FUNERAL HOME St Louis, Mo
25. DATE RECD. BY LOCAL REG. 12-23-1961
26. REGISTRAR'S SIGNATURE James A Lewis Jr. Dep

(Licensed Embalmer's Statement on Reverse Side)

DEC 28 1961

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 Jack W. Rose

Licensed Embalmer No. 4643

P. O. Address Marshall, M

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.