

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003509

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1401 STATE FILE NUMBER

AMENDED

~~FILE~~ FEB 7 1962

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| 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, Missouri | | c. CITY OR TOWN St. Louis, Missouri | |
| Length of stay in 1b -- | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Hamilton Med. Center | | d. STREET ADDRESS <u>956 Hamilton Dr</u> Hamilton Med. Center | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|---------------------------|---|---|---------------------------------------|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last EMMA *** BORCK | | | 4. DATE OF DEATH Month Day Year January 31, 1962 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH July 2, 1864 | 9. AGE (last birthday) 97 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Single | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT University City, Mo. Opal Blackburn, 6820 Delmar Blvd. | | |

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| 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 <u>± 4 yrs</u> <u>year</u> |
| IMMEDIATE CAUSE (a) <u>arteriosclerotic C.V. Disease</u> | | | |
| DUE TO (b) <u>art. Sclerosis, gen'd</u> | | | |
| DUE TO (c) <u>422.1</u> | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho pneumonia</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 | | |
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| 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.) | | | |
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|--|--|------------------------------|--|--------|-------|
| 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 |

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| 21. I attended the deceased from <u>Feb 9/1962</u> to <u>1/31/62</u> and last saw her alive on <u>1/27/62</u> Death occurred at <u>9:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
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| 22a. SIGNATURE (Degree or title) <u>Arthur E. Stroud, M.D.</u> | | | 22b. ADDRESS <u>3720 Washington</u> | | 22c. DATE SIGNED <u>2/1/62</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE Feb. 1, 1962 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory | 23d. LOCATION (City, town, or county) St. Louis County, Missouri |
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| 24. FUNERAL DIRECTOR C.R. LUPTON & SONS, 7233 Delmar Blvd | | 25. DATE RECD. BY LOCAL REG. FEB 1 1962 | 26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ BY AFFIDAVIT OF

JH 3-6525

1:30 PM

City
Deane G. Koppert
1058line

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 _____

*not embalmed
Howard Wright*

Licensed Embalmer No. _____

P. O. Address _____

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.