

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044822

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11458**

STATE FILE NUMBER

**FILED DEC 7 1962**

VS 300	DATE AMENDED
Rev. 4/59	
1	
4806-321	
3	
4 1	
5 0	
6	
7 0	
8 1	
9	
10	
11	
12 84-0	
13	
84	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>University City</b>	
Length of stay in lb <b>3 Days</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>St. Louis Childrens</b>		d. STREET ADDRESS (If outside, give location) <b>8136 Vardaman Drive</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Debra Joy Schankman</b>		4. DATE OF DEATH Month Day Year <b>11-22-62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>11-19-62</b>
9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min. <b>3 3</b>		IF UNDER 24 HR.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</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>Raymond B. Schankman</b>		13b. MOTHER'S MAIDEN NAME <b>Lorraine Hartstein</b>	
14. NAME OF HUSBAND OR WIFE <b>None</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 <b>Mary Foust</b>		Address <b>500 S. Kingshighway</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>Respiratory Failure</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Post-op Repair of Tracheo- Esophageal Fistula</b>			
DUE TO (c) <b>756.2</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1) Imperforate Anus 2) Dysplastic Rt. Kidney</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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>11-19-62</b> to <b>11-22-62</b> and last saw her alive on <b>11-22-62</b>		Death occurred at <b>9:30 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Edward T. Barker M.D.</b>		22b. ADDRESS <b>500 S. Kingshighway</b>	
22c. DATE <b>11-24-62</b>		22c. DATE SIGNED (State) <b>11/24/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-30-1962</b>	23b. DATE	23c. NAME <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Rowland Mortuary Svc.</b>	ADDRESS <b>4104-06 Manchester</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 29 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_

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.