

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037742

9627 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9627

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b DOA	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5220 Robert</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>John</u> Last <u>Kory</u>			4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1963</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/1912</u>	9. AGE (last birthday) <u>51</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>upholsterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bachman Company</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Kory</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Steffel</u>		14. NAME OF HUSBAND OR WIFE <u>Gertrude</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			17. INFORMANT Address <u>Gertrude Kory 5220 Robert</u>		

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
IMMEDIATE CAUSE (a) <u>Gunshot wound of the head with fractured laceration of the brain and brain hemorrhage; following self inflicted rifle shot in home on or about 9/25/63; WHILE SUFFERING A TEMPORARY MENTAL ABERRATION.</u>		<u>skull;</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u>SUICIDE</u>		
DUE TO (c) <u>SUICIDE</u>		
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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>see above</u>
20c. TIME OF INJURY Hour <u>9/25/63</u> a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis, Missouri</u> COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>3:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <u>Paul J. Simon</u> (Degree of Registrar)		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>9/27/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>9/28/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>
24. FUNERAL DIRECTOR <u>John L Ziegenhein & Sons</u> ADDRESS <u>7027 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 27 1963</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF

MEDICAL CERTIFICATION DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

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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 Donald Bony

Licensed Embalmer No. 94863

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.