

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045333

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11173**

STATE FILE NUMBER

FILED NOV 22 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri		Length of stay in 1b 7 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis		c. CITY OR TOWN Creve Coeur		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 715 Trojan Dr.				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Della M. Cordes			4. DATE OF DEATH Month Day Year November 9 1963			5. SEX F		6. COLOR OR RACE W		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 8-6-1897		9. AGE (last birthday) 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Homes		11. BIRTHPLACE (City and state or country) Creve Coeur, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Fred S. Kopadt				13b. MOTHER'S MAIDEN NAME Lizzie Wuellner				14. NAME OF HUSBAND OR WIFE John H. (dcd)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Freda Kopadt-715 Trojan-Creve Coeur Address			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bulbar Palsy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cachexia 356.1 DUE TO (c) Amyotrophic lateral sclerosis										INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 1 yr. 1 1/2 yrs. plus	
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 checked="" 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 November 7, 1963 to November 9 and last saw her/him alive on November 9, 1963 Death occurred at 1:10 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Deceased or title) Janice L. Steen M.D.						22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 11/10/63		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-12-1963		23c. NAME OF CEMETERY OR CREMATORY St. Paul's E & R Cem.		23d. LOCATION (City, town, or county) (State) Olivette, Mo.					
24. BAUMANN BROS. INC. FUNERAL HOME 2504 WOODSON ROAD OVERLAND 14, MISSOURI						25. DATE RECD. BY LOCAL REG. NOV 12 1963		26. REGISTRAR'S SIGNATURE Road Smith, M.D.			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DATE AMENDED  
 ITEM NO. SHOULD READ  
 BY AFFIDAVIT OF  
 MEDICAL CERTIFICATION  
 DOCUMENT  
 1 VS 300 Rev. 4/59  
 2 4012  
 3  
 4 1  
 5 2  
 6  
 7 1  
 8 1  
 9  
 10  
 11  
 12 52-0  
 13  
 52  
 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

*David C. Gibson*

Licensed Embalmer No.

*34524*

P. O. Address

*St L 14 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.