

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3305

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>103</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>6 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>201 North Third Street</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert</u> b. (Middle) _____ c. (Last) <u>Stempel</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>January 1, 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 9, 1873</u>			
9. AGE (in years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>		11. BIRTHPLACE (State or foreign country) <u>Osage County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Ewald Stempel</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Seidner</u>			14. NAME OF HUSBAND OR WIFE <u>Grace Clifton</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>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Grace Stempel St. Charles, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebrum of liver</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  <u>46 1/5</u> <u>13</u>						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Nov 14, 1949</u> , to <u>Jan 1, 1949</u> that I last saw the deceased alive on <u>Jan 1, 1949</u> and that death occurred at <u>11:17 m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>J. B. Foster, M.D.</u>				23b. ADDRESS <u>440 Missouri Trust Building</u>		23c. DATE SIGNED <u>5/1/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		24b. DATE <u>January 6, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
DATE REC'D BY LOCAL REG. OFFICE <u>JAN 5 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Haeflman - Rose, Inc. - St. Charles Mo.</u>					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 11 1977

**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.

Signed Frederic W. Bane

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4607

P. O. Address St. Charles, 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 this body is not embalmed, fact should be so stated above.