

21719

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5740

No. 300
10-48

FILED JUL 15 1949

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1005 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5900 McPHERSON AVE		d. STREET ADDRESS (If rural, give location) 5900-McPHERSON AVE.	

3. NAME OF DECEASED (Type or Print) NELLIE STAED			4. DATE OF DEATH (Month) (Day) (Year) JULY 1-1949		
a. (First)		b. (Middle)	c. (Last)		

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH SEPT. 22 1882	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 9	Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEGRAPH OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY WESTERN UNION	11. BIRTHPLACE (State or foreign country) ST. LOUIS MO.	12. CITIZEN OF WHAT COUNTRY? O
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13a. FATHER'S NAME THOMAS STAED	13b. MOTHER'S MAIDEN NAME MARY O'MALLEY	14. NAME OF HUSBAND OR WIFE SINGLE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME AGNES STAED	ADDRESS 5900 McPHERSON
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>arteriosclerosis heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH 5970
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>General arterial calcification</i>		
	DUE TO (c) <i>Stroke</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) ST. LOUIS MO. 97
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500
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22. I hereby certify that I attended the deceased from 1944, to July 1, 1949; that I last saw the deceased alive on 6-30, 1949, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Joseph J. Donnelly M.D.</i>	23b. ADDRESS 634 21 Street	23c. DATE SIGNED 7-1-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 4th-1949	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. <i>M. J. 2</i>	REGISTRAR'S SIGNATURE <i>J. B. Sasser</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur J. Donnelly</i>	ADDRESS 3840 Lindell
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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AT Corning
Two Weeks

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Thomas R. Benwick

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3793

P. O. Address _____

3840 Linden

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.