

FILED NOV 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35198**
Registrar's No. **9495**

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY Missouri | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri | | | | b. COUNTY _____ | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis) | | c. LENGTH OF STAY (in this place) 8Y4M15D | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Chronic Hospital | | | | e. STREET ADDRESS (If rural, give location) 13 5600 Arsenal | | | | 213 7/0 | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Ida | | | b. (Middle) Mae | | | c. (Last) Stevens | | | |
| 4. DATE OF DEATH (Month) (Day) (Year) 10 19 1955 | | | 5. SEX Female | | | 6. COLOR OR RACE White | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single | | | 8. DATE OF BIRTH ? ? / 1866 | | | 9. AGE (In years last birthday) ab 88 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | | 11. BIRTHPLACE (City and State or Foreign Country) Missouri | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13a. FATHER'S NAME unk | | | 13b. MOTHER'S MAIDEN NAME unk | | | |
| 14. NAME OF HUSBAND OR WIFE _____ | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____ | | | 16. SOCIAL SECURITY NO. _____ | | | |
| 17. INFORMANT'S SIGNATURE OR NAME Chronic Hospital | | | ADDRESS 5600 Arsenal | | | _____ | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis | | | | | | years | |
| | | DUE TO (c) Diabetes Mellitus | | | | | | years | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. cachexia Multiple Decubital Ulcers | | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION 260x | | | | | | 20. AUTOPSY? YES <input 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) _____ | | 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 6/3 , 19 47 ; to 10/19 , 19 55 that I last saw the deceased alive on 10/19 , 1955, and that death occurred at 9:55A m., from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE George M. Tanaka, M.D. (Degree or title) | | | | 23b. ADDRESS 5600 Arsenal | | | | 23c. DATE SIGNED Oct 19, 1955 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) _____ | | 24b. DATE OCT 31 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board | | 24d. LOCATION (City, town, or county) St. Louis, Mo. (State) _____ | | | |
| DATE REC'D BY LOCAL REG. OCT 31 1955 | | REGISTRAR'S SIGNATURE J. Carl Schmidt M.D. | | | | FUNERAL DIRECTOR'S SIGNATURE W. H. Leonard ADDRESS St. Louis Mo | | | |

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

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.