

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **3029**
Registrar's No. **110**

FILED JAN 17 1956

318

PRIMARY REG. DIST. NO. 1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 110			
1. PLACE OF DEATH a. COUNTY _____				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 town or township) St. Louis		c. LENGTH OF STAY (in this place) 3 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital				e. STREET ADDRESS (If rural, give location) 4360 Clayton avenue				21890	
3. NAME OF DECEASED (Type or Print) ISABELLA			a. (First)		b. (Middle)		c. (Last) STAHL		
4. DATE OF DEATH (Month) (Day) (Year) 1-4-56			5. SEX female			6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 6-10-1886			9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Horan			13b. MOTHER'S MAIDEN NAME unknown Tansey			14. NAME OF HUSBAND OR WIFE Joseph Stahl,			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joseph Stahl, 4360 Clayton ave.				
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) Cancer of Bladder				INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
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. Harm. of Bladder				1 mo.	
19a. DATE OF OPERATION 1/20/56		19b. MAJOR FINDINGS OF OPERATION Bleeding						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 181x					
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 1/15, 1956 , to 1/4, 1956 , that I last saw the deceased alive on _____, 19____, and that death occurred at 9:30 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) M. P. W. Borch				23b. ADDRESS 1504 P. Grand Ave			23c. DATE SIGNED 1/5/56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1-5-56		24c. NAME OF CEMETERY OR CREMATORY Ressurrection Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. JAN 5 1956		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland-Aker, 4104 Manchester ave.					

(Licensed Embalmer's Statement on Reverse Side)

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..... *Bert Hoffman*

Licensed Embalmer No. *43*

P. O. Address *St. Louis*

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.