FILED APR 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11469

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3032

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 2 6530 Parkwood Place 2021

3. NAME OF DECEASED (Type or Print)
a. (First): THERESA
b. (Middle):
c. (Last): STAEHLE

4. DATE OF DEATH (Month) (Day) (Year): 3-26-1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 4-17-1878

9. AGE (In years last birthday): 77 | 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:

11. BIRTHPLACE (City and State or Foreign Country): Hungary

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: John Staehle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S SIGNATURE OR NAME: John Staehle
ADDRESS: 6530 Parkwood Place

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.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cholelithiasis — 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

DUE TO (c)

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: 5-84X

20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 1050 A m., from the causes and on the date stated above.*

23a. SIGNATURE: Patrick C. Taylor (Degree or title): Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 3-26-56.

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 3-29-1956

24c. NAME OF CEMETERY OR CREMATORY: Sunset Burial Park

24d. LOCATION (City, town, or county) (State): 10160 Gravois Road Mo

DATE REC'D BY LOCAL REG.: MAR 26 1956

REGISTRAR'S SIGNATURE: Earl Smith

25. FUNERAL DIRECTOR'S SIGNATURE: McGinnis Bros
ADDRESS: 6409 Gravois Ave

(Licensed Embalmer's Statement on Reverse Side)

FEB 6 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate w

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 HANDWRITIN
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.