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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 36235 8778

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N.Grand,St.Louis,Mo. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Vet.Adm.Hospital — Length of stay in 1b: 3 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JEFFERSON
c. CITY OR TOWN: DE SOTO — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): ROUTE NO.3 — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: LEO Middle: — Last: STAFFELBACH

4. DATE OF DEATH Month: 9 Day: 19 Year: 56

5. SEX: MALE **6. COLOR OR RACE:** WHITE **7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-23-94 **9. AGE** (In years last birthday): 61 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): State Highway Department **10b. KIND OF BUSINESS OR INDUSTRY:**

11. BIRTHPLACE (City and state or country): VICTORIA, MISSOURI **12. CITIZEN OF WHAT COUNTRY?** USA

13. FATHER'S NAME: LOUIS STAFFELBACH **14. MOTHER'S MAIDEN NAME:** SARAH FORESTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-I **16. SOCIAL SECURITY NO.:** 490 14 7948 **17. INFORMANT** Address: VA Hosp.Records,915 N.Grand,St.Louis, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3-1/2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): MIDDLE CEREBRAL ARTERY THROMBOSIS
DUE TO (c): 332X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **20e. PLACE OF INJURY** (e. g., in or about home, farm, factory, street, office bldg., etc.) **20f. CITY, TOWN, OR LOCATION** COUNTY STATE

21. I attended the deceased from 9-16-56, to 9-19-56 and last saw ~~her~~ him alive on 9-19-56
Death occurred at 7:25 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. T. Kaminskas M.D. **22b. ADDRESS:** 915 N.Grand Blvd. VA Hosp. St.Louis, Mo. **22c. DATE SIGNED:** 9-19-56

23a. BURIAL, CREMATION, REMOVAL (Specify): removal **23b. DATE:** 9-20-56 **23c. NAME OF CEMETERY OR CREMATORY:** **23d. LOCATION** (City, town, or county) (State): Crystal City, Mo.

24. FUNERAL DIRECTOR ADDRESS: Cady F.Home, Crystal City, Mo. **25. DATE RECD. BY LOCAL REG.:** SEP 24 1956 **26. REGISTRAR'S SIGNATURE:** J Earl Smith md

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

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

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.
– 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.