

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39836**  
Registrar's No. **10253**

FILED NOV 30 1956

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|  |  |  |                       |  |                           |   |   |   |  |   |  |  |  |
|--|--|--|-----------------------|--|---------------------------|---|---|---|--|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>318</b>  |                       | PRIMARY REG. DIST. NO. <b>1003</b>   |                           | Registrar's No. <b>10253</b>  |   |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |  |                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> |                           |   |   |   |  |   |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>St. Louis</b>   |  | c. LENGTH OF STAY (In this place)<br><b>2 WKS.</b>   |                       | c. CITY OR TOWN <b>Richmond Heights</b>  |                           | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |   |  |   |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>  |  |  |                       | e. STREET ADDRESS (If rural, give location)<br><b>7342 Goff Ave.</b>   |                           |   |   |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>ALLA</b>  |  |  | b. (Middle) <b>B.</b> |  | c. (Last) <b>STINGLEY</b> |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Nov. 8th 1956</b> |   |  |   |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>  |                       | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>   |                           | 8. DATE OF BIRTH <b>Aug. 17 1868</b>  |   | 9. AGE (In years last birthday) <b>88</b>   |  | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>21</b> |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____             |  |
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired)<br><b>Housewife</b>   |  |  |                       | 10b. KIND OF BUSINESS OR INDUSTRY _____  |                           | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Butler City, Iowa</b>  |   |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |  |  |
| 13a. FATHER'S NAME<br><b>James E. Burke</b>  |  |  |                       | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Beaver</b>  |                           |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Thomas B. Stingley</b>                            |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |  |                       | 16. SOCIAL SECURITY NO. <b>none</b>  |                           | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Gladys Betts 7342 Goff Ave.</b>   |   |   |  |   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                            |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Aortic - sclerotic heart disease</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>heart failure</b><br>DUE TO (c) <b>pulmonary edema.</b><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                       |  |                           |   |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>20 yrs.</b> |  |
| 19a. DATE OF OPERATION<br><b>none</b>  |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>none</b>  |                       |  |                           |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><b>None</b>  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>  |                       | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><b>420.0</b>  |                           |   |   |   |  |   |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>None</b>   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                       | 21f. HOW DID INJURY OCCUR?<br><b>None</b>  |                           |   |   |   |  |   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>10-22, 1956</b> , to <b>11-8, 1956</b> , that I last saw the deceased alive on <b>11-8, 1956</b> , and that death occurred at <b>10:15 P. m.</b> , from the causes and on the date stated above. |  |  |                       |  |                           |   |   |   |  |   |  |  |  |
| 23a. SIGNATURE (Degree or title)<br><b>Herbert P. Heinbach M.D.</b>  |  |  |                       | 23b. ADDRESS<br><b>7200 Manchester</b>   |                           |   |   | 23c. DATE SIGNED<br><b>11-9-56</b>  |  |   |  |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 24b. DATE<br><b>Nov. 10 1956</b>   |                       | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Glendale Masonic Cem</b>  |                           | 24d. LOCATION (City, town, or county) (State)<br><b>Des Moines, Iowa.</b>   |   |   |  |   |  |  |  |
| DATE REC'D BY LOCAL REG.<br><b>NOV 9 1956</b>  |  | REGISTRAR'S SIGNATURE<br><b>Carl Smith</b>   |                       |  |                           | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>A.H. Bocklage 6536 Clayton Rd.</b>   |   |   |  |   |  |  |  |

*m.j.b.* (Licensed Embalmer's Statement on Reverse Side)

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

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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..... *Elmo K. Cedeno*

Licensed Embalmer No...407...

P. O. Address *So 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.