

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15327

FILED MAY 6 - 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's **3794**

Health,
& Welfare
Public
Service

S. 300
V. 1-56

Doctor, coroner, etc: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN ST. LOUIS, MO. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Brentwood 17 400 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTE BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Reside on Farm 9372 Sonora Ave Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TILLIE Middle NMN Last STEVENS			4. DATE OF DEATH Month APRIL Day 19 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov, 13, 1874
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Champion City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Martin.	
14. MOTHER'S MAIDEN NAME Elizabeth Wilson.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO none	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Andrew M. Stevens; 9372 Sonora Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 4-5 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) PYOCYANEUS INFECTION OF ABDOMINAL WALL WOUND			
DUE TO (c) GASTRO INTESTINAL HEMORRHAGES			4 MOS.
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 578x		
20c. TIME OF INJURY Hour _____ Month, Day, Year a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 APRIL 11, 1957 to APRIL 19, 1957 and last saw her APR. 19, 1957 alive on APR. 19, 1957 Death occurred at 5:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. E. Vannellia, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 4/20/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-22-1957	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. APR 22 '57	26. REGISTRAR'S SIGNATURE Carl Smith MO m8 B

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 *Arnold W. Schoene*

Licensed Embalmer No. *386*

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.