

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15201

FILED MAY 13 1957

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1059

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Berkeley</u>		c. CITY OR TOWN <u>St. Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>7 1/2 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>Highway # 40, Rt. # 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Edgewood Retreat</u>			

3. NAME OF DECEASED a. (First) <u>MARION</u> b. (Middle) _____ c. (Last) <u>STUMBERG</u>			4. DATE OF DEATH <u>April 21, 1957</u> (Month) (Day) (Year)		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10, 1879</u>	9. AGE (In years last birthday) <u>78</u>	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) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>

13a. FATHER'S NAME <u>John E. Kriete</u>	13b. MOTHER'S MAIDEN NAME <u>Lucinda Budd</u>	14. NAME OF HUSBAND OR WIFE <u>Dr. B. Kurt Stumberg</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H. K. Stumberg</u> ADDRESS <u>St. Charles, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>Seven yr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arteriosclerosis</u>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	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 6/9, 1955, to 4/21, 1957, that I last saw the deceased alive on 4/20, 1957, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph P. Sanders, M.D.</u> (Degree or title)	23b. ADDRESS <u>4621 N. Taylor Ave St. Louis 8 Mo</u>	23c. DATE SIGNED <u>4/22/57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Apr. 24, 1957</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4-22-57</u>	REGISTRAR'S SIGNATURE <u>Hebeard B. Sooker</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>William C. Bauer</u> ADDRESS <u>St. Charles, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUL 21 1958

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 *Clarence M. Billa*

Licensed Embalmer No. *4375*

P. O. Address *St. Charles, Mo.*

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.