

Health
Welfare
Public
Service

300
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 causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1957

318

1003

26606

STATE FILE NUMBER
5675

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

| | | | |
|--|--|--|---|
| 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) OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Lemay 4880 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony | | Length of stay in lb 6 hrs. | d. STREET ADDRESS (If outside, give location) 1004 Van Nostrand 27 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | | | | | |
|--|----------------------------------|---|--|---|---|
| 3. NAME OF DECEASED (Type or print) First LOUISE Middle Last STEPHAN | | | 4. DATE OF DEATH Month June Day 16 Year 1957 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 22, 1951 | 9. AGE (In years last birthday) 6 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) St. Louis, Mo | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Stephan, Jr. | | | 14. MOTHER'S MAIDEN NAME Mary Fields | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Charles Stephan, Jr. Address 1004 VanNostrand | | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) General Debility | | INTERVAL BETWEEN ONSET AND DEATH 2 years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Congenital malformation nervous system | 6 year |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute gastroenteritis | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) 753.1 | |
| 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 **Sept 2, 1953** to **June 16, 1957** and last saw her **him** alive on **June 13, 1957**. Death occurred at **St. Anthony Hosp.** on the date stated above; and to the best of my knowledge, from the causes stated.

| | | |
|--|-------------------------------------|------------------------------------|
| 22a. SIGNATURE M. R. Wilucki M.D. (Office or title) | 22b. ADDRESS 8916 Gravais | 22c. DATE SIGNED 6-18-57 |
|--|-------------------------------------|------------------------------------|

| | | | |
|---|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE June 19, 1957 | 23c. NAME OF CEMETERY OR CREMATORY National Cem. | 23d. LOCATION (City, town, or county) (State) Jeff, Brks, Mo. |
|---|-----------------------------------|--|---|

| | | |
|---|--|---|
| 24. FUNERAL DIRECTOR ADDRESS Fendler Und. Co., 7420 Michigan Ave. | 25. DATE RECD. BY LOCAL REG. JUN 18 57 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P. |
|---|--|---|

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

54026 Georgia
12:45 Sharp

INDEMNITY

1919

ST. ANTHONY

1001 WEST

ST. ANTHONY

ST. ANTHONY

June 16, 1922

WHITE

WHITE

6

Feb. 23, 1921

White

Female

USA

St. Louis, Mo

None

None

Larry Florida

Charles St. Anthony

STATEMENT BY LICENSED EMBALMER

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

by me, or by Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Harvey Kahle*

Licensed Embalmer No. 45

P. O. Address *Flou...*

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.

Embalmer, Inc. 2000 ... Ave.