

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007881

STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

2304

300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS MO</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>LUTHERAN Hosp.</i>		Length of stay in 1b	d. STREET ADDRESS (If outside give location) <i>2220 1340 St. Angelo St.</i>		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. NAME OF DECEASED (Type or print) First Middle Last <i>EDWARD J. STUMPF, JR</i>			4. DATE OF DEATH Month Day Year <i>FEB. 23 1958</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 30 1899</i>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>58</i> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BEER BOTTLER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FALSTAFF</i>		11. BIRTHPLACE (City and state or country) <i>Mo.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13a. FATHER'S NAME <i>EDWARD STUMPF</i>		13b. MOTHER'S MAIDEN NAME <i>ELIZABETH MARES</i>	
14. NAME OF HUSBAND OR WIFE <i>—</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service) <i>YES WART</i>		16. SOCIAL SECURITY NO. <i>488-05-7142</i>	
17. INFORMANT <i>DOLORES DYERLY</i>		Address <i>6717 Kenwood Dr</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Possible Pulmonary Embolus</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>following Gastroenteritis for 3 days</i> DUE TO (c) <i>alcohol</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>540.0</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>needed 2-23</i>	
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.) <i>540.0</i>		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <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 <i>1/5</i> to <i>2/23</i> and last saw her/him alive on <i>2/23/58</i> Death occurred at <i>6:50 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Ralph Perry MD</i>		22b. ADDRESS <i>3203 S. Grand Ave</i>		22c. DATE SIGNED <i>2/24/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>FEB. 27 1958</i>		23c. NAME OF CEMETERY OR CREMATORY <i>S. S. PETER & PAUL</i>	
23d. LOCATION (City, town, or county) <i>ST. LOUIS</i>		23e. STATE <i>MO</i>		23f. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	
24. GENERAL DIRECTOR ADDRESS <i>Thomas Kuter 2906 Gravis</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 25 '58</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be related. All diseases in Part I must be causally related.

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 *Samuel Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906*

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.