Health, & Welfare Public Service
. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030986
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7581

FILED SEP 15 1958

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Faith Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St. Louis
c. CITY OR TOWN: Bellefontaine Neighbors — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 10245 Unicorn Dr. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: EDWIN Middle: H. Last: STAHL

4. DATE OF DEATH: Month August Day 3rd Year 1958

5. SEX: Male **6. COLOR OR RACE**: white **7. MARRIED** [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: June 10-1904

9. AGE (In years last birthday): 54 — 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): clerk
10b. KIND OF BUSINESS OR INDUSTRY: P.O. Dept.
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: George Stahl
13b. MOTHER'S MAIDEN NAME: Mathilda Schaller
14. NAME OF HUSBAND OR WIFE: Alice Stahl

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 Address: Alice Stahl, 10245 Inicorn Dr.

USE ONLY BLACK INK OR RIBBON. TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 420.1
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 Oct 21, 57 to Aug 3, 58 and last saw her/him alive on Feb 58
Death occurred at 2.30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: M. A. Cassel (Degree or title): MD
22b. ADDRESS: 3400 N. Kingshighway
22c. DATE SIGNED: 8/4/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 8/6/58
23c. NAME OF CEMETERY OR CREMATORY: New Bethlehm Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS: DIEDRICH FUNERAL HOME, 8319 Hallsferry
25. DATE RECD. BY LOCAL REG.: AUG 4 '58
26. REGISTRAR'S SIGNATURE: Earl Smith MD
M.D.

(Licensed Embalmer's Statement on Reverse Side)

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.

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 John J. Stains

Licensed Embalmer No. 4108

P. O. Address Skowhegan Me.

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.