

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034741  
STATE FILE NUMBER  
9412  
Registrar's No.

FILED OCT 10 1958

Registration District No.

318

Primary Registration District No.

1003

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Good Samaritan		d. STREET ADDRESS 4500 Washington Good Samaritan	
3. NAME OF DECEASED (Type or print) First Middle Last Della L. Stuart		4. DATE OF DEATH Home 9 29 58	
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 Apr. 24, 1880
9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Holstein, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME George W. Stuart		13b. MOTHER'S MAIDEN NAME Lenore Pepperling	
14. NAME OF HUSBAND OR WIFE Good Samaritan Home		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 Good Samaritan Home	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 443x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)		19. INTERVAL BETWEEN ONSET AND DEATH 2 days 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory/street/office bldg., etc.) 5/4/53	
20e. CITY, TOWN, OR LOCATION St. Louis		20f. COUNTY STATE Mo.	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ p m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Hugo F. Bergman M.D.	
22b. ADDRESS 3720 Washington		22c. DATE SIGNED 9/30/58	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10/2/58	
23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Mo.	
24. FUNERAL DIRECTOR Drehmann-Harral		25. DATE RECD. BY LOCAL REG. OCT 1 58	
26. REGISTRAR'S SIGNATURE Cash Smith Mo			

Dr. H. F. Bergman  
3720 Washington  
Hrs. 2 - 3 PM

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 *Albert R. Thompson* .....

Licensed Embalmer No. *4237* .....

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.