

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038467
STATE FILE NUMBER

FILED OCT 27 1958 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2700

1. PLACE OF DEATH a. COUNTY St. Louis		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 Brentwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Brentwood 4511
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gouldworth Home		Length of stay in 1b 9 Days	d. STREET ADDRESS (If outside, give location) 2638 Melvin Ave.
3. NAME OF DECEASED (Type or print) First ELSIE Middle NMI Last STEIN			4. DATE OF DEATH Month Oct. Day 19, Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1879
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) Wittenberg, Germany 4
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Unknown Lense	13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE William Stein		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 Anna VonArx, Rock Hill, Mo.		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) Generalized arteriosclerosis DUE TO (c) 331X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 1/2	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		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 _____ 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 10-11-58 , to 10/20/58 and last saw her alive on 10/18/58 Death occurred at 2:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title) MD		22b. ADDRESS Kirkwood, Mo.	
22c. DATE SIGNED 10-20-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 10-22-58		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	
23d. LOCATION (City, town, or country) (State) St. Louis Co., Mo.		24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo	
25. DATE RECD. BY LOCAL REG. 10-21-58		26. REGISTRAR'S SIGNATURE [Signature]	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. Allen Jones Jr*
Licensed Embalmer No. *4053*
P. O. Address *STL*

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.