

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003532
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 299

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1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
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 Incarnate Word Hospital		Length of stay in lb 203 ^d STREET ADDRESS 2136 Knox (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Charles Stambaugh			4. DATE OF DEATH Month Day Year Jan 8 1959		
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5. SEX MALE <input type="checkbox"/>	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 29, 1898	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME CHARLES E STAMBAUGH	13b. MOTHER'S MAIDEN NAME LILLIAN ANDREWS	14. NAME OF HUSBAND OR WIFE MARIE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give dates of service) YES WW-1	16. SOCIAL SECURITY NO. 499-01-2878	17. INFORMANT MARIE STAMBAUGH Address 2136 KNOX
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - Heart DUE TO (b) Bronchitis - DUE TO (c) At the time of pneumonia - Terminal - 241X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) acute upper respiratory infection precipitated Heart Failure		INTERVAL BETWEEN ONSET AND DEATH long standing 6 days
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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.) precipitated Heart Failure
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
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21. I attended the deceased from Jan 2, 6:50A to Jan 8 and last saw her alive on Jan 4, 59. Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Clarence Y. Deussen M.D.	(Degree or title)	22b. ADDRESS 1927 A Mission	22c. DATE SIGNED 1-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1/12/1959	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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24. FUNERAL DIRECTOR J L ZIEGENHEIN & SONS	ADDRESS 7027 GRAVOIS	25. DATE RECD. BY LOCAL REG. JAN 10 59	26. REGISTRAR'S SIGNATURE Earl Smith Mo
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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 *E. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Gravel*

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.**