Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003539
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 585

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY
b. CITY OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN ST. LOUIS, — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET.ADM.HOSPITAL — Length of stay in 1b 118 DAYS	d. STREET ADDRESS (If outside, give location) 2814 VICTOR AVE. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First LESTER Middle I. Last STEPHENS				4. DATE OF DEATH Month 1 Day 16 Year 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH 1/17/18	9. AGE (In years last birthday) 40	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) ASSEMBLER	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) GREENVILLE, MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME IRBY STEPHENS		13b. MOTHER'S MAIDEN NAME BEULAH JOHNSON		14. NAME OF HUSBAND OR WIFE OLIVIA STEPHENS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. 489188322	17. INFORMANT VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	SUPERIOR VENAL OBSTRUCTION	1 Month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	BRONCHOGENIC CARCINOMA	5 Months
DUE TO (c)	162.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): PLEURAL EFFUSION

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE [X]	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 VA attended the deceased from 9/19/58, to 1/16/59 and last saw him alive on 1/16/59. Death occurred at 10:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J.B. Shields MD (Degree or title) M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 1/16/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-20-59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette	ADDRESS	25. DATE RECD. BY LOCAL REG. 1-17-59	26. REGISTRAR'S SIGNATURE J. Carl Smith - MD acm

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 H. G. Farris

Licensed Embalmer No. 33814

P. O. Address H. Farris

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.