Health, & Welfare Public Service

300
1-57

75

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003541
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 864

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Chronic Hosp. — Length of stay in 1b: 1 yr. 4 mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3225 Montgomery — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Alex Middle: Last: Stetson
4. DATE OF DEATH: Month 1 Day 19 Year 59
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-4-89
9. AGE (In years last birthday): 69 — 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): Unk
10b. KIND OF BUSINESS OR INDUSTRY: unk
11. BIRTHPLACE (City and state or country): unk.
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: -- unk
13b. MOTHER'S MAIDEN NAME: -- unk
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: Oscar Schaefer P.A., Civil Courts Bldg.

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) Art. mid. Cerebral Art. Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 15 mo.
DUE TO (c) Generalized Arteriosclerosis — 15 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 332X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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 9-5-57, to 1-19-59 and last saw her/him alive on 1-19-59
Death occurred at 11:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John M. Beckham, M.D. (Degree or title)
22b. ADDRESS: 5800 Arsenal
22c. DATE SIGNED: 1/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1/27/1959
23c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cem.
23d. LOCATION (City, town, or county) (State): Jennings, Missouri

24. FUNERAL DIRECTOR: Morrell Mortuary, ADDRESS: 3710 North Grand
25. DATE RECD. BY LOCAL REG.: JAN 26 '59
26. REGISTRAR'S SIGNATURE: Carl Smith MD
MDB

(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 Loron E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis, Mo

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.