

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003834
STATE FILE NUMBER

REGISTRATION DISTRICT No. 317 Primary REGISTRATION DISTRICT No. 545 REGISTRAR'S No. 329

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 Maplewood Inside Limits Yes No

c. CITY OR TOWN Maplewood 4544 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3101 Cherry St. Length of stay in lb yrs.

d. STREET ADDRESS 3101 Cherry St. (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
CATHERINE STAED

4. DATE OF DEATH Month Day Year
Feb. 1, 1959

5. SEX female 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED WIDWED 2 DIVORCED

8. DATE OF BIRTH June 1878 9. AGE (In years at birthday) 80 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (City and state or country) Ireland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Lavin 13b. MOTHER'S MAIDEN NAME Calligan 14. NAME OF HUSBAND OR WIFE Michael C. Staed

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. nrk 17. INFORMANT Address Wm. E. Doyle, nephew, 3101 Cherry St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
DUE TO (c) _____

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

19. WAS AUTOPSY PERFORMED? YES NO 2

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 Month, Day, Year a.m. p.m. _____

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 Jan 1, 1959 to Feb 1, 1959 and last saw her alive on Jan 24, 1959
Death occurred at 2:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Vincent J Poursend MD 22b. ADDRESS 3101 Sutton Ave Maplewood Mo 22c. DATE SIGNED 2-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify) removal 23b. DATE Feb. 3, 1959 23c. NAME OF CEMETERY OR CREMATORY Calvary Cem. 23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS M. J. Croghan, 7146 Manchester Av. 25. DATE RECD. BY LOCAL REG. 2-2-59 26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

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 *Harvey Kahle*

Licensed Embalmer No. *4596*.....

P. O. Address *Florissant, 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.