

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011410

STATE FILE NUMBER
2 2495
Registrar's No.

FILED MAR 25 1959

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri 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 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4443 Washington	

3. NAME OF DECEASED (Type or print) First Thomas Middle Stanfield Last			4. DATE OF DEATH Month 3 Day 7 Year 59		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1887	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	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) Porter	10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	11. BIRTHPLACE (City and state or country) Vicksburg Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME PHILLIP STANFIELD	13b. MOTHER'S MAIDEN NAME AGNES SHEED	14. NAME OF HUSBAND OR WIFE Eda Stanfield
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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. 492-09-8968	17. INFORMANT Miss Myrtle Stanfield	Address 4443 Washington
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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) Cardiac Insufficiency		INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic heart disease	DUE TO (c) 420.0	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	

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.)
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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
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21. I attended the deceased from 2-10-59 to 3-7-59 and last saw ^{him} alive on 3-7-59 Death occurred at 4:58 P on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T.A. Mason (Degree or title) , M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 3-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/11/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) 5500 Brown, St. Louis, Mo
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24. FUNERAL DIRECTOR Geo. W. Brown ADDRESS 4469 Washington	25. DATE RECD. BY LOCAL REG. MAR 11 '59	26. REGISTRAR'S SIGNATURE Loan South. M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

CAUSES 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 *Frederick P. Stark*

Licensed Embalmer No. *4599*.....
P. O. Address *St. Louis*.....

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.