

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011422
STATE FILE NUMBER

FILED APR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. 3113

300
-57

2

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 St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital # 1		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3904 No. 23rd, St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Last Stephenson			4. DATE OF DEATH Month March Day 25 Year 1959			
5. SEX Male	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 1888 April 17, 1886	9. AGE (In years last birthday) 72 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Canada 2	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Stephenson Stephenson		13b. MOTHER'S MAIDEN NAME Annie Anderson		14. NAME OF HUSBAND OR WIFE Grace		

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. 197-0204	17. INFORMANT Grace Stephenson, 3904 No. 23rd, St. Address
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary carcinoma with metastasis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____	163x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) ITEM 2, 9 6-5-58 PRES CORRECTED
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	BY: 1. AFFIDAVIT OF Funeral Director 2. DOCUMENT Family Record Book 4-17-1988

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 St. Louis	COUNTY St. Louis	STATE
21. I attended the deceased from March 22, 1959 to March 25, 1959 and last saw her alive on March 25, 1959 Death occurred at 6:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Joseph Michael III M.D.	22b. ADDRESS 1515 Lafayette Ave	22c. DATE SIGNED Mar. 25, 1959
--	---	--

23a. BURIAL (CREMATION) REMOVAL (Specify) Removal	23b. DATE 3-28-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
---	-----------------------------	---	---

24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. MAR 27 59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
---	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 *Sam W. Walker*

Licensed Embalmer No. *35717*

P. O. Address *Ad. House*

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.