

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011790

STATE FILE NUMBER

FILED MAR 23 1959

Registration District No.

317

Primary Registration District No.

590

Registrar's No.

704

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 Florissant		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Florissant		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 837 Charbonier Rd.		Length of stay in lb 5 yrs.	d. STREET ADDRESS 837 Charbonier Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Roy Dooley Stephens			4. DATE OF DEATH March 14, 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 Feb. 15, 1893	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter		10b. KIND OF BUSINESS OR INDUSTRY Lincoln-Mercury	11. BIRTHPLACE (City and state or country) Salem, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Fielding Stephens		13b. MOTHER'S MAIDEN NAME Susan McGee		14. NAME OF HUSBAND OR WIFE Lilly Pearl Stephens	
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. unk.	17. INFORMANT Address Lilly P. Stephens, 837 Charbonier Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA, GENERALISED					INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
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)					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.) 2001		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK 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	
21. I attended the deceased from DECEMBER 1957 to 14 MARCH 1959 and last saw her/him alive on 14 MARCH 1959 Death occurred at 8-30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Robert A. Mayer M.D.			22b. ADDRESS 950 FRANCIS PLACE CLAYTONS MO		22c. DATE SIGNED 3/16/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-17-59	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		23d. LOCATION (City, town, or county) (State) Salem, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 3-17-59	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *J. W. Brubaker*

Licensed Embalmer No. *3653*

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.