

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027251

FILED VS JUL 24 1959

2 6380

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		Length of stay in 1b		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Enroute City Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4025a McPherson, Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Kent</u> Middle <u>Leon</u> Last <u>Stockwell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-1922</u>		9. AGE (last birthday) <u>36</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder Century Elec. Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Co.</u>		11. BIRTHPLACE (City and state or country) <u>Attic, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Thomas Stockwell</u>			13b. MOTHER'S MAIDEN NAME <u>Stella Broadway</u>			14. NAME OF HUSBAND OR WIFE <u>Mildred</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>429-28-9532</u>		17. INFORMANT <u>Mildred Stockwell, 4025a McPherson, Ave.</u>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (a) <u>Bilateral Basilar Skull Fractures with subdural and subarachnoid hemorrhage and pontine and peduncular hemorrhage.</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not listed on the terminal disease condition given <u>shuffled in fall over railing into the stairs</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>fell from bathroom in home at 4025 McPherson Ave. on the 4th of July, 1959. about</u>					
20c. TIME OF INJURY Hour <u>3:45</u> a.m. Month, Day, Year <u>7 4 59</u>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from <u>411A</u> to <u> </u> and last saw her alive on <u> </u> . Death occurred at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Patrick F. Taylor Coroner</u>				22b. ADDRESS <u>1300 Clark</u>				22c. DATE SIGNED <u>7-6-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>6-6-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Local</u>		23d. LOCATION (City, town, or county) <u>Pochantas, Arkansas</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>				25. DATE RECD. BY LOCAL REG. <u>JUL 6 59</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> <u>WFB</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. Binkley

Licensed Embalmer No. _____

P. O. Address _____

365
St Louis 8

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.