

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027255

FILED VS AUG 4 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

2 6862

STATE FILE NUMBER

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		Length of stay in 1b 28 years	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6262 Delor		d. STREET ADDRESS (If outside, give location) 6262 Delor	
3. NAME OF DECEASED (Type or print) First Middle Last Gladys Stolle		4. DATE OF DEATH Month Day Year July 22, 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/28/1899
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	9. AGE (last birthday) 60
13a. FATHER'S NAME William G. Liethegner		13b. MOTHER'S MAIDEN NAME Gora McGee	14. NAME OF HUSBAND OR WIFE Henry C. Stolle
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. None	17. INFORMANT Address Henry C. Stolle, 6262 Delor, St. Louis
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO (b) CARCINOMA of OVARY DUE TO (c) 175.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 4 mo + 7 mo. +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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	
21. I attended the deceased from 3 June 59 to 22 July 59 and last saw her alive on 20 July 59 Death occurred at 6:40 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John J. McClain M.D.		22b. ADDRESS 4401 Hampton	
22c. DATE SIGNED 22 July 59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/25/1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 6464 Chippewa Street, St. Louis, Missouri		25. DATE RECD. BY LOCAL REG. JUL 23 '59	26. REGISTRAR'S SIGNATURE Loal Smith. M.D. mgs

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bill C. Branson

Licensed Embalmer No. 4769

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.