RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1959

59-030967

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2228

DED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: St. Louis,
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Clayton.
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis Co. Hosp. D.O.A
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: ST LOUIS
c. CITY OR TOWN: Affton,
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 8910 Blackpool Dr.
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First THERESA Middle Last STALLMAN
4. DATE OF DEATH: Month Aug. Day 13th Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: 2-27-1884
9. AGE (last birthday): 75
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Charles G. May
13b. MOTHER'S MAIDEN NAME: Agnes Windolph
14. NAME OF HUSBAND OR WIFE: Late Ralph Stallman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 494-03-7237
17. INFORMANT: Ruth Montgomery
Address: 8910 Blackpool Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Natural Causes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 ____, to ____ and last saw her/him alive on ____
Death occurred at 8:21P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John C. Murphy M.D.
John C. Murphy MD Actg Health Commissioner
22b. ADDRESS: 801 S. Brentwood Clayton, Mo.
22c. DATE SIGNED:

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 20, 1959
23c. NAME OF CEMETERY OR CREMATORY: Calvary
23d. LOCATION (City, town, or county): St. Louis,
(State): Mo.

24. FUNERAL DIRECTOR: Kriegshaiser
ADDRESS: 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG.: 8-18-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed R. W. Storsand

Signature of Student Embalmer

Licensed Embalmer No. 4007

P. O. Address_____

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