

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-034374

FILED VS SEP 22 1959

2 8093

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		c. CITY OR TOWN Lemay (25)	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		d. STREET ADDRESS (If outside, give location) 612 Bellewirth Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine T. Stuhlman			4. DATE OF DEATH Month Day Year Aug. 29, 1959
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/9/75
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Genevieve, Mo.
12a. FATHER'S NAME Leo Herzog		12b. MOTHER'S MAIDEN NAME Caroline Eichenlaub	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		14. SOCIAL SECURITY NO. None	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		16. INFORMANT Address (25) George L. Hanbeck 612 Bellewirth Dr.	
IMMEDIATE CAUSE (a) cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 days.	
DUE TO (b) generalized arteriosclerosis.		15 yrs.	
DUE TO (c) Fracture of rt femur 15 days previously.		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	
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	18. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell to floor at home	
20c. TIME OF INJURY Hour ? a.m. p.m.	Month, Day, Year 8-14-59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION COUNTY STATE Lemay St. Louis Mo.	
21. I attended the deceased from 1958 to death and last saw her alive on Aug 29 59 Death occurred at 4:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John G. Kellest W.D.		22b. ADDRESS 2314 Telegraph Road.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 2, 1959	
23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) (State) Saint Louis (23) Mo.	
24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan Ave.		25. DATE RECD. BY LOCAL REG. SEP 1 1959	
26. REGISTRAR'S SIGNATURE Carl Smith. M.D.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr John G. Killeat
7314 Telegraph Rd.
In 2-0044

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

W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7420 Mic

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.