

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034837

FILED OCT 13 1959 317

Registration District No. Primary Registration District No. 590 Registrar's No. 2620

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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>Rural Wellston</u>		c. CITY OR TOWN <u>Crystal City</u>	
Length of stay in 1b <u>3yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>303 Jefferson</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Frank</u> Last <u>Stackley</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</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>Jan. 29, 1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HR Hours <u> </u> Min.
-----------------------	----------------------------------	---	--	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>P. P. G. Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Genevieve, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	--	--	--

13a. FATHER'S NAME <u>Joe Stackley</u>	13b. MOTHER'S MAIDEN NAME <u>Regina Grass</u>	14. NAME OF HUSBAND OR WIFE <u>wife, Mrs. Elizabeth Stackley,</u>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unkn.</u>	16. SOCIAL SECURITY NO. <u>unkn.</u>	17. INFORMANT <u>Mrs. Elizabeth Stackley, wife, 303 Jefferson, Crystal City, Mo.</u>
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
IMMEDIATE CAUSE (a)	<u>Bronchial Pneumonia</u>	
DUE TO (b)	<u>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</u>	
DUE TO (c)	<u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		Years <u> </u>
PART III. If deceased was female was there a pregnancy in last 90 days.		Years <u> </u>
		Years <u> </u>
		<input type="checkbox"/> Yes <input 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 <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u>
---	------------------------------

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.)	20f. CITY, TOWN, OR LOCATION <u>Crystal City, Mo.</u>	COUNTY <u> </u> STATE <u> </u>
---	--	--	--------------------------------------

21. I attended the deceased from 9-14-59 to 10-1-59 and last saw her/him alive on 10-1-59
Death occurred at 2:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. B. Lytton</u> (Degree or title) <u>md</u>	22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>	22c. DATE SIGNED <u>10/1/59</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-5-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	23d. LOCATION (City, town, or county) <u>Crystal City, Mo.</u>	(State)
--	-----------------------------	---	---	---------

24. FUNERAL DIRECTOR <u>Gentry R. Politte</u>	ADDRESS <u>Crystal City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-3-59</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>
--	-------------------------------------	--	--

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

WS OCT 14 1959

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 Anthony R. Polite

Licensed Embalmer No. 5081

P. O. Address Crystal

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.