

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042564

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **210857**

UNDECEASED

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 St. Louis		Length of stay in 1b 1 mo.		a. STATE Missouri		b. COUNTY Washington		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Cadet, R#1		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. STREET ADDRESS Kingston Twp.				Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Preston Stephenson				4. DATE OF DEATH Month Day Year Nov. 23, 1959				
5. SEX Male	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 Mar. 6, 1892	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder - Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cherokee, Iowa		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Theo. Milton Stephenson			13b. MOTHER'S MAIDEN NAME Blanche Augusta Ankeny			14. NAME OF HUSBAND OR WIFE Elsie Stephenson		
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 Alice Widmar, Cadet, R#1				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute massive hemorrhage from DUE TO (b) duodenal ulcer DUE TO (c) 541-0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 hr?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerotic Heart Disease & Auric. Fibrillation						PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Nov. 10, 1959 to Nov. 23, 1959 and last saw her alive on 11-23-59 Death occurred at 3:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) James T. McTadden Jr. M.D.				22b. ADDRESS 950 Francis Place			22c. DATE SIGNED 11-24-59	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11-27-1959	23c. NAME OF CEMETERY OR CREMATORY St. Joachims Cemetery		23d. LOCATION (City, town, or county) Old Mines, Mo.		(State)		
24. FUNERAL DIRECTOR Smith Funeral Home, Potosi, Mo.				25. DATE RECD. BY LOCAL REG. NOV 24 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.			

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 C. H. Boyer

Licensed Embalmer No. 4158

P. O. Address Potosi

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.