URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-042567

FILED VS DEC 7 1959

STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ 210005

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St.Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis | Length of stay in 1b

c. CITY OR TOWN Ferguson | Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital | Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 450 Mueller | Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Charles Middle: Raymond Last: Stevens

4. DATE OF DEATH Month: October Day: 29 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 2/2/1929

9. AGE (last birthday): 30

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): Metal Finisher

10b. KIND OF BUSINESS OR INDUSTRY: Ford Motor Co.

11. BIRTHPLACE (City and state or country): Black Oak, Ark.

12. CITIZEN OF WHAT COUNTRY: U.S.

13a. FATHER'S NAME: Charley E. Stevens

13b. MOTHER'S MAIDEN NAME: Ruth Lane

14. NAME OF HUSBAND OR WIFE: Wilma

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.: 432-48-4895

17. INFORMANT: Wilma Stevens, Address: 450 Mueller

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma of Sigmoid Colon | INTERVAL BETWEEN ONSET AND DEATH: 1 yr

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c) 153.3

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 Oct 15, 1958 to Oct 29, 59 and last saw ~~her~~ him alive on 10/28/59

Death occurred at 8:20 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M D Johnson M.D. (Degree or title)

22b. ADDRESS Ferguson Mo

22c. DATE SIGNED 10/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11-1-59

23c. NAME OF CEMETERY OR CREMATORY: Local Cemetery

23d. LOCATION (City, town, or county) (State): Blythesville, Ark.

24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc., ADDRESS: 4700 Washington Blvd.

25. DATE RECD. BY LOCAL REG.: OCT 31 1959

26. REGISTRAR'S SIGNATURE: Noal Smith M D

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harvey Kahle

Signature of Student Embalmer

Licensed Embalmer No. 4596

P. O. Address Florissant,

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