

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 4 6 4

FILED VS DEC 21 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3358 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>McLearn</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS 60</u>		Length of stay in 1b <u>3 Weeks</u>		c. CITY OR TOWN <u>Bloomington</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>Peace Haven Nurs. Home</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>508 Lafayette Apts.</u>		
3. NAME OF DECEASED (Type or print) First <u>Melita</u> Middle <u>Edwards</u> Last <u>Stoddard</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1959</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/4/1876</u>		
				9. AGE (last birthday) <u>83</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Minonk, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Bela M. Stoddard</u>			13b. MOTHER'S MAIDEN NAME <u>Sara Bell</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Bloomington, Illinois</u> <u>Mr. & Mrs. Donald M. Laughlin</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
DUE TO (b) <u>Arterial Sclerotic Heart Disease</u>							<u>6 months</u>	
DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema Senile & Fracture of Rt. Hip.</u>							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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input 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.)				
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 <u>12/9/59</u> to <u>12/12/59</u> and last saw her alive on <u>12/15/59</u> Death occurred at <u>3:30PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Charles Brumside M.D.</u>				22b. ADDRESS <u>208 W. Argonne</u>			22c. DATE SIGNED <u>12/16/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>12/16/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Pfitzinger Mortuary, Kirkwood 22, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-16-59</u>		26. REGISTRAR'S SIGNATURE <u>Jahn C. Murphy M.D.</u>		

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 Ben E. Hoffman

Licensed Embalmer No. 436

P. O. Address St. Louis

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.