

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JAN 22 1960

-60-004102

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-187** STATE FILE NUMBER

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 34 Yrs. | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2711a Hadley Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First WALTER Middle WILLIAM Last STEHLIN | | | 4. DATE OF DEATH Month JANUARY Day 5 Year 1960 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/16/25 | 9. AGE (last birthday) 34 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Job Pressman | | 10b. KIND OF BUSINESS OR INDUSTRY James H. Forbes | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Jake Stehlin | | 13b. MOTHER'S MAIDEN NAME Theresa O'Neil | | 14. NAME OF HUSBAND OR WIFE Norma Stehlin | |
| 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. 490 22 7305 | 17. INFORMANT Address Norma Stehlin, 2711a Hadley | | |

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|---|---|--|
| 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 15 MINUTES |
| IMMEDIATE CAUSE (a) IRREVERSIBLE FIBRILLATION | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) RHEUMATIC HEART DISEASE | 20 YEARS |
| | DUE TO (c) _____ | 416x |
| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|--------------|
| 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 _____ 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 **FEB. 12, 1949** to **JAN. 5, 1960** and last saw her/him alive on **JAN. 5, 1960**
 Death occurred at **10:35 A. M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>C. O. Vermillion, M.D.</i> (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 1/5/60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 1-8-60 | 23c. NAME OF CEMETERY OR CREMATORY Lakewood Park |
| 24. FUNERAL DIRECTOR McLaughlin; 2301 Lafayette(4) ADDRESS | 25. DATE RECD. BY LOCAL REG. JAN 7 1960 | 26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Chapman

Licensed Embalmer No. 45

P. O. Address A. Town

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