

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013769

FILED VS. APR 5 1960 317

Registration District No. 500

Registrar's No. 932

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				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 County		Length of stay in 1b 5 mos.		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 Home Halls Ferry Nursing			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3905a Castleman		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First ELMON Middle OTTO Last STACY				4. DATE OF DEATH Month March Day 16 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 1/9/1900		9. AGE (last birthday) 60		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) Maint. Man				10b. KIND OF BUSINESS OR INDUSTRY Mfg. Co. Crunden Martin		11. BIRTHPLACE (City and state or country) Unk. Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME William Stacy				13b. MOTHER'S MAIDEN NAME Mary J. Kelly				14. NAME OF HUSBAND OR WIFE Sarah Stacy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address St. Louis Sarah Stacy, 3905a Castleman, Mo.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses, multiple Cerebral malacia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral malacia DUE TO (c) Arteriosclerotic cerebrovascular disease										INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x								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					
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 3, 1960 to March 16, 1960 and last saw him alive on March 14, 1960 Death occurred at 3:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE - Lewis Littmann M.D. (Degree or title)				22b. ADDRESS 8231 Clayton Rd (17)				22c. DATE SIGNED 3/18/60 (State)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/21/60		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery				23d. LOCATION (City, town, or county) St. Louis Co., Mo.					
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, St. Louis ADDRESS				25. DATE RECD. BY LOCAL REG. 3-19-60		26. REGISTRAR'S SIGNATURE J. B. Murphy M.D.							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. LITTMAN
8231 CRYSTAL RD.
3-5- FRIDAY

SEP 20 1981

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 St. Louis

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.