

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017371

FILED VS APR 29 1960

2 3854

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>3 weeks days</b>	c. CITY OR TOWN <b>Aftton,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hospitals, Inc.,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>7631 General Meade Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>John</b> Last <b>Stiffler</b>			4. DATE OF DEATH Month <b>April</b> Day <b>5,</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1912</b>	9. AGE (last birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>wire products</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John C. Stiffler</b>		13b. MOTHER'S MAIDEN NAME <b>Cornelia J. Nahr</b>		14. NAME OF HUSBAND OR WIFE <b>Eunice Krite</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>490-03-4648</b>	17. INFORMANT Address <b>Eunice Stiffler, 7631 General Meade Lane</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INTESTINAL HEMORRHAGE Rec</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 Hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CEREBRAL METASTASIS</b>					<b>3 Mos</b>	
DUE TO (c) <b>CARCINOMA OF LUNG RT. UPPER CEREBRAL</b>					<b>5 Mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>HEMIPLEGIA RT. COMPLETE. DUE TO CEREBRAL METASTASIS</b>					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. (E.g., nature of injury in PART I or PART II of item 18.) <b>163x</b>				
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 <b>10-23-59</b> to <b>April 5, 1960</b> and last saw <sup>him</sup> <del>her</del> alive on <b>April 5, 1960</b> Death occurred at <b>8:10 P.M.,</b> _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Amel Stiffler M.D.</i> (Degree or title)			22b. ADDRESS <b>1755 So. Grand Blvd.,</b>		22c. DATE SIGNED <b>4/6/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>April 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Belderwieden Funeral Home, Inc.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 7 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

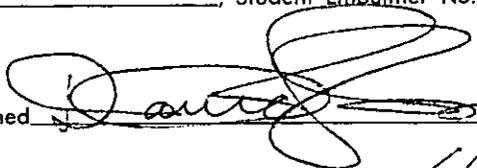
1936 St. Louis Avenue

(Licensed Embalmer's Statement on Reverse Side)

**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  \_\_\_\_\_

Licensed Embalmer No. 452

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.