

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036938

LED VS. SEP 19 1960

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2712 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>4 DAYS</b>	c. CITY OR TOWN <b>Olivette,</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 Marys Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>#59 Tealwood Dr.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>GENEVA</b> Last <b>STEVENS</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>13,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-1884</b>	9. AGE (last birthday) <b>76</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>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	11. BIRTHPLACE (City and state or country) <b>Ballard Co. Ky.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert A. Rils</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown Adams</b>		14. NAME OF HUSBAND OR WIFE <b>Late Elijah Stevens</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>None</b>	17. INFORMANT <b>Mrs. Gladys Dunkel-#59 Tealwood Dr.</b> Address
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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
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>		<i>4 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>arteriosclerotic heart disease</i>	<i>10 years</i>
DUE TO (c)		
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 checked="" 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 8-10-59 to 9-13-60 and last saw her/him alive on 9-12-60  
Death occurred at 6:40 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>John A. Kriegshauser M.D.</i>	22b. ADDRESS <i>950 Francis Place Clayton Mo</i>	22c. DATE SIGNED <i>9-13-60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Motor</b>	23b. DATE <b>9-15-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cem.</b>
23d. LOCATION (City, town, or county) <b>Belleville, Ill.</b>		(State)

24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser-9450 Olive Str. Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>9-13-60</b>	26. REGISTRAR'S SIGNATURE <i>John A. Kriegshauser M.D.</i>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed R.W. Stovessand

Licensed Embalmer No. 4007

P. O. Address H. Lou

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