

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-037083

FILED VS SEP 19 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2653

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>Manchester</b>	Length of stay in lb <b>2 Mons.</b>	c. CITY OR TOWN <b>Des Peres:</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>Manchester Nurs. Home</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2062 N. Ballas Rd.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>STEVENS</b> Last	4. DATE OF DEATH Month <b>Sept.</b> Day <b>7,</b> Year <b>1960.</b>
---	--

5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>Jan. 5, 1869</b>	9. AGE (last birthday) <b>91</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HR. Hours <b></b> Min. <b></b>
-----------------	---------------------------	---	--------------------------------------	----------------------------------	---	---

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>HOME</b>	11. BIRTHPLACE (City and state or country) <b>Chillicote, Ohio</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	---	--

13a. FATHER'S NAME <b>Schoeling</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Charles 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>Olivette Leritz</b> Address <b>2062 N. Ballas Rd</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>CARCINOMA OF STOMACH</b>	INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SENILITY</b>	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 <b></b> a.m. <b></b> p.m. <b></b> Month, Day, Year <b></b>	
--	--

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 <b>BALLWIN, Mo.</b> COUNTY <b></b> STATE <b></b>
--	--	--

21. I attended the deceased from **APRIL 8, 1959** to **SEPT 7, 1960** and last saw her alive on **9-6-60**  
Death occurred at **11:20 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>B. R. Koenig M.D.</b> (Degree or title)	22b. ADDRESS <b>BALLWIN, Mo.</b>	22c. DATE SIGNED <b>9-8-60</b>
--	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Sept. 9, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR <b>A.H. Bocklage</b> ADDRESS <b>F.H. 6536 Clayton Rd.</b>	25. DATE RECD. BY LOCAL REG. <b>9-9-60</b>	26. REGISTRAR'S SIGNATURE <b>J. B. Murphy M.D.</b>
---	---	---

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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Elmer R. Padon

Licensed Embalmer No. 4077

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.