

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040594

FD VS NOV 9 1960 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3223 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 b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Normandy		Length of stay in lb DOA	c. CITY OR TOWN Wellston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6323a Ella Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle A. Last Stallins			4. DATE OF DEATH Month November 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 3/5/1909	9. AGE (last birthday) 51 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Lincoln Engineering Co.		11. BIRTHPLACE (City and state or country) Fulton, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Robert Stallins			13b. MOTHER'S MAIDEN NAME Maggie Jones		14. NAME OF HUSBAND OR WIFE Elsie Laverne Stallins		

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. 189-09-1136		17. INFORMANT Address Elsie Laverne Stallins, 6323a Ella Ave.			
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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: IMMEDIATE CAUSE (a) Cardiac decompensation						INTERVAL BETWEEN ONSET AND DEATH 4 m	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Myocardial Infarction					12 months
		DUE TO (c) Coronary Sclerosis					4 m.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Relapsing Pancreatitis & Paget's Disease						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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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	
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21. I attended the deceased from **Nov 1959** to **Nov 5, 1960** and last saw him alive on **10/21/60**
Death occurred at **5:50** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William D. McHaven, M.D.			22b. ADDRESS 7811 Carondelet Clayton, Mo 63114			22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-9-60		23c. NAME OF CEMETERY OR CREMATORY Purcell Cemetery		23d. LOCATION (City, town, or county) (State) Paragould Ark.		

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. 11-7-60		26. REGISTRAR'S SIGNATURE John E. Murphy, M.D.			
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.