

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961 318 Primary Registration District No. 1003 Registrar's No. 12388 -60-042956 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Mo		Length of stay in 1b	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 Firmin Desloge Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5370 Pershing		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last FINIS M STAMPER			4. DATE OF DEATH Month Day Year Dec 24 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/7/1882	9. AGE (last birthday) 78	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) Retired Mgr Arcady Milling Co		10b. KIND OF BUSINESS OR INDUSTRY Chicago Ill	11. BIRTHPLACE (City and state or country) Clifton Hill Mo		12. CITIZEN OF WHAT COUNTRY U.S. A.
13a. FATHER'S NAME Joseph Stamper		13b. MOTHER'S MAIDEN NAME Alice Johnson Cobb		14. NAME OF HUSBAND OR WIFE Anna M. Stamper	

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. yes	17. INFORMANT Margaret Stamper 902 Buckeye		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>					INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
DUE TO (b) <i>Coronary artery thrombosis</i>					12 hrs.
DUE TO (c) <i>420-1</i>					

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Diabetes Mellitus</i>			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 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 *March, 1958* to *Dec 24, 1960* and last saw ^{him} alive on *Dec 24, 1960*
Death occurred at *3:30* p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Charles Silimberg, M.D.</i>		22b. ADDRESS <i>462 N. Taylor Ave.</i>		22c. DATE SIGNED <i>12/26/60</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <i>12/27/1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County Mo</i>	

24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar		25. DATE RECD. BY LOCAL REG. DEC 26 1960	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
--	--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

F. M. Stamper
City Vice
Dr. Silverberg
Office
HOME

462 No Taylor.
FR. 1-4711
WY 4-7227

Case 11:15 home

45 Rio Vista

Pa 582288

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 Arnold W. Sch

Licensed Embalmer No. 386

P. O. Address St. Louis

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.