

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-011618
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2246

AMENDED

FILED VS MAR 16 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		
		St. Louis		32 Years		c. CITY OR TOWN		St. Louis		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		D.O.A., St. Louis City Hosp		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
						4059 Westminister Pl				
3. NAME OF DECEASED (Type or print) First Middle Last					4. DATE OF DEATH Month Day Year					
James Dave Stanfill					March 4, 1961					
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Widowed <input type="checkbox"/>	Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR		
Male	White			6/11/1911	49	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY			
Butcher			Wellston, Mo		Arkansas		U.S.A.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
Dell G. Stanfill			Genora Pierce			None				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					17. INFORMANT					
No None					Mrs Margaret E. Migneco 6405a Arsenal St					
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)										
Punctured Aorta - Fractured skull with subdural Hemorrhage; suffered when struck by car operated by one, Sabin Bronkny, in front of 3894 Washington Ave, about 7:43 p.m. on March 4, 1961. ACCIDENT.										
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO								
		DUE TO								
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.)								
		See above								
20c. TIME OF INJURY Hour 7:43 a.m. p.m.		Month, Day, Year 3-4-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	
				19 Street		St Louis		Mo		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title)					22b. ADDRESS			22c. DATE SIGNED		
[Signature] Deputy Coroner					1300 Clark			3-7-61		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)			
Burial		3/7/61		Laurel Hill Gardens			St. Louis Co, Missouri			
24. FUNERAL DIRECTOR				25. DATE REC'D. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE				
Alexander & Sons 6175 Delmar Blvd				MAR 7 1961		Loan Smith, M.D.				

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jos. E. McCallister

Licensed Embalmer No. 2766

P. O. Address 6170 Oldano

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.