OURT DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-042921
STATE FILE NUMBER

FILED NOV 28 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10833

AMENDED

1. PLACE OF DEATH
a. COUNTY —
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis
Length of stay in 1b: 2 Mos.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY St. Louis
c. CITY OR TOWN St. Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 7528 Comfort Ave
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Frankie; Middle Davies; Last Stephens
4. DATE OF DEATH: Month 11; Day 20; Year 61
5. SEX: M
6. COLOR OR RACE: W
7. Married ☐ Never Married ☑ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-17-50
9. AGE (last birthday): 11
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HR: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Scholar
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Little Rock Ark
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Woodrow Wilson Stephens
13b. MOTHER'S MAIDEN NAME: Frances M Kaufman
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Record Address

MEDICAL CERTIFICATION

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)	Acute Respiratory Obstruction	3 HR.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Mucous Secretions – Obstructive Emphysema	3 HR
DUE TO (c)	Post-Operative – Esophagectomy	12 HR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Bantis Syndrome – Chronic Malnutrition – Esophageal Stricture

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 539.1
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 August 1961, to 11-20-61 and last saw her/him alive on 11-20-61
Death occurred at 845 PM – 11-20-61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William T. Mallitt MD
22b. ADDRESS: 307 S. Euclid
22c. DATE SIGNED: 11-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-22-1961
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town, or county): Kirkwood (State): Mo
24. FUNERAL DIRECTOR: Mittelberg ADDRESS: Webster Groves Mo
25. DATE RECD. BY LOCAL REG.: NOV 21 1961
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4108

P. O. Address _____

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