

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH -61-042922

DEPARTMENT OF PUBLIC HEALTH AND WELFARE
 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10737 STATE FILE NUMBER

AMENDED
 DATE PREPARED
 ITEM NO.
 SHOULD READ
 BY AFFIDAVIT OF

FILED NOV 28 1961

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo. b. COUNTY _____
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 d. STREET ADDRESS 4944 Wise Ave (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First CHL Middle _____ Last STEVENS 4. DATE OF DEATH Month NOVEMBER Day 17 Year 1961

5. SEX Male 6. COLOR OR RACE Cau. 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 4-3-1894 9. AGE (last birthday) 67

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (City and state or country) KENTUCKY 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Frank Stevens 13b. MOTHER'S MAIDEN NAME Maggie Copland 14. NAME OF HUSBAND OR WIFE Vesta Stevens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 17. INFORMANT Address Vesta Stevens 4944 Wise Ave

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
 DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE YEARS
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) 420.0H

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) SUSPECTED CHRONIC MYELOGENOUS LEUKEMIA 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.) _____

20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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 JULY 3, 1959 to NOV. 17, 1961 and last saw her alive on NOVEMBER 17, 1961
 Death occurred at 9:05 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D. 22b. ADDRESS BARNES HOSPITAL 22c. DATE SIGNED 11/18/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 11-20-61 23c. NAME OF CEMETERY OR CREMATORY Mansonic Cemetery 23d. LOCATION (City, town, or county) (State) Mill Creek, Missouri

24. FUNERAL DIRECTOR ADDRESS McLaughlin 2301 Lafayette Ave 25. DATE RECD. BY LOCAL REG. NOV 20 1961 26. REGISTRAR'S SIGNATURE [Signature]

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 James R. Chapman
Licensed Embalmer No. 4550
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.