

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-046910

FILED JAN 11 1962

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12390

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in lb 19 hours	c. CITY OR TOWN Florissant #9 Ranchview Drive
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" 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"/>
3. NAME OF DECEASED (Type or print) First Middle Last Minnie M Stumpf			4. DATE OF DEATH Month Day Year December 30 1961
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-3-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri
13a. FATHER'S NAME - - - Schultz		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, pp. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Edwin A. Stumpf, #9 Ranchview Drive
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>Influenza of cause of pneumonia</i> DUE TO (b) <i>influenza + bacterial heart disease + viral</i> DUE TO (c) <i>420.0</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Thrombosis of left iliac artery</i>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Month, Day, Year a.m. p.m.			
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 <i>12/29/61</i> to <i>12/30/61</i> and last saw her him alive on <i>12/29/61</i> Death occurred at <i>8 PM 12/30/61</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>James C. Vest m.d.</i>		22b. ADDRESS <i>634 N Grand</i>	22c. DATE SIGNED <i>1/1/62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Jan. 3, 1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>	23d. LOCATION (City, town, or county) <i>St. Louis Missouri</i>
24. FUNERAL DIRECTOR <i>Math Hermann &amp; Son, Inc., 2161 E. Fair Ave St. Louis, 7, Missouri</i>		25. DATE RECD. BY LOCAL REG. <i>JAN 2 1962</i>	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>

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 by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Harold B. Berridge*

Licensed Embalmer No. 4202

P. O. Address *H. Jones*

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.