

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004590

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

412

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO.</i> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Length of stay in 1b <i>46 YRS.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>DOA CITY HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>3015 KOSSUTH</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>JOHN</i> Middle <i>D.</i> Last <i>STILES</i>			4. DATE OF DEATH Month <i>1</i> Day <i>9</i> Year <i>1962</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>12-29-1894</i>	9. AGE (last birthday) <i>67</i>	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) <i>RETIRED MILLWRIGHT</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>LUMBER CO.</i>		11. BIRTHPLACE (City and state or country) <i>SEARCY, ARK.</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13a. FATHER'S NAME <i>LUM STILES</i>		13b. MOTHER'S MAIDEN NAME <i>JANE UNK.</i>		14. NAME OF HUSBAND OR WIFE <i>ANNA F. STILES</i>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES W W I</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>ANNA F. STILES 3015 KOSSUTH</i>	
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Atherosclerosis</i>		
	DUE TO (c) <i>Premature Senility</i>		

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. <i>33ix</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)			
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				
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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
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21. I attended the deceased from *1951* to *1-9-1962* and last saw him alive on *1-7-1962*
Death occurred at *2:30 A* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Joseph Kessler M.D.</i>	22b. ADDRESS <i>3504 N 15th</i>	22c. DATE SIGNED <i>1-10-62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>1-11-1962</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MEMORIAL PARK</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS COUNTY, MO.</i>
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24. FUNERAL DIRECTOR ADDRESS <i>SUEDMEYER SONS 3934 N. 20TH ST.</i>	25. DATE RECD. BY LOCAL REG. <i>JAN 10 1962</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith. M.D.</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis Mo

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.