

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-021047

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5534

FILED JUN 15 1962

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH COUNTY City of St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. STATE Mo. | | b. COUNTY Oregon | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Thayer | |
| Length of stay in lb 2 mo. 29 days | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Frisco Employes' Hosp. | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |

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|-------------------------------------|--------|------|------------------|-----|------|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First | Middle | Last | Month | Day | Year |
| Sidney A. Still | | | June 1, 1962 | | |

| | | | | | | | | |
|----------------|---------------------------|---|-------------------------------|------------------------------|---------------------------|------------------------|-------------------------|------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-21-1914 | 9. AGE (last birthday) 48 | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | IF UNDER 24 HR Hours | IF UNDER 24 HR Min. |
|----------------|---------------------------|---|-------------------------------|------------------------------|---------------------------|------------------------|-------------------------|------------------------|

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

| | | |
|-------------------------------------|--|---|
| 13a. FATHER'S NAME William Still | 13b. MOTHER'S MAIDEN NAME Roxie Constantine | 14. NAME OF HUSBAND OR WIFE Opal Still |
|-------------------------------------|--|---|

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|--|-------------------------|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address Opal Still Thayer, Mo. |
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| 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 approxi- mately 4-15-62 |
| IMMEDIATE CAUSE (a) Glioblastoma Multiforme | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Respiratory Insufficiency DUE TO (c) (and pontine hemorrhage) | |

| | | |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 193-0 | | 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 |
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| 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.) |
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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 |
|--|--|---|

21. I attended the deceased from March 3, 1962 to June 1, 1962 and last saw him alive on June 1, 1962
Death occurred at 9:31 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>James W. Stiles Jr. M.D.</i> | 22b. ADDRESS 4960 Laclede, St. Louis, Mo. | 22c. DATE SIGNED 6-1-62 |
|---|--|----------------------------|

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|--|---------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 6-4-62 | 23c. NAME OF CEMETERY OR CREMATORY Local | 23d. LOCATION (City, town, or county) (State) Thayer, Missouri |
|--|---------------------|---|---|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd. | 25. DATE RECD. BY LOCAL REG. JUN 2 1962 | 26. REGISTRAR'S SIGNATURE <i>Opal Smith M.D.</i> |
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JUN 19 1962
AUG 14 1962

JUN 18 1962

JUL 10 1962

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 Stanley H. Hixson
Licensed Embalmer No. 4193

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.