

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030562

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7185 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

FILED JUL 19 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>2 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		d. STREET ADDRESS (if outside, give location) <u>2921 a Keokuk</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alpha Wiarda Stumpf</u>			4. DATE OF DEATH Month Day Year <u>July 8, 1963</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-26-80</u>
9. AGE (last birthday) <u>82</u>		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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>William Griepenburg</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Siemans</u>	
14. NAME OF HUSBAND OR WIFE <u>Henry Stumpf</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT <u>Mrs. Wiarda Paul</u>		Address <u>3009 Solway Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> Conditions; if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus 420.0</u>			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 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.)
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 <u>12/7/56</u> to <u>7/8/1963</u> and last saw her alive on <u>7/8/63</u> Death occurred at <u>8:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John A. Smith M.D.</u>		22b. ADDRESS <u>1 Clarkson Rd Chesterfield Mo</u>	
22c. DATE <u>7/9/63</u>		22d. DAY SIGNED <u>7/9/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7-11-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Churchyard</u>		23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>	
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 11 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>			

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 USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT
 DATE AMENDED
 1/2
 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

John S. Penney

Licensed Embalmer No. 41940

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.

Dr. Lee Hawkins
1, Clarkston Rd.
KE 2-3466

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