

No. 2
4-13-40
3-17-39
DI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34047

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8744

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 weeks
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Catherine Stiles

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Andrew 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased About 1852
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day
About 88 hr. _____ min.

9. Birthplace Philadelphia Penn.
(City, town, or county) (State or foreign country)

10. Usual occupation At Home 9

11. Industry or business _____ 9

12. Name Not Known 9

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Marcelina F. Stiles

(b) Address 1328 Midland Ave.,

17. (a) Bellefontaine (b) Date thereof Oct 24, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director A. Row 250 W. Co.

(b) Address 2707 N. Grand Blvd.

19. (a) OCT 23 1940 (b) _____
(Date received for local use) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")
(d) Street No. 4359 Taft Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1940 hour 4 minutes 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Arotic Stenosis with
Chronic Interstitial Myocarditis;
Contrib: Chronic Endocarditis;
Endarteritis Obliterous of left
Due to Arteriosclerosis;
Arteriosclerosis;
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (By means of injury)

23. Signature Alfred J. Stiles (M. D. or other) _____
Address _____ Date signed 10/23/40

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Paul F. Kucelenberg

Licensed Embalmer No. *2631*

P. O. Address *2707 N. Grand*

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 this body is not embalmed, fact should be so stated above.