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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

FILED OCT 25 1945 STANDARD CERTIFICATE OF DEATH

State File No. **32417**
8547
Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1003

1. 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:
City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 Montgomery St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

William D. Stevens

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: December 14 1898
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 9 10 hr. min.

9. Birthplace: Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business Unemployed

MOTHER FATHER { 12. Name Sherman Stevens
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Laura Resp
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Viola Jensen
(b) Address 2830 A. Osage St

17. (a) Burial (b) Date thereof Oct 5 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Gezenheim Bros
(b) Address OCT 3 6609 Gravois Ave

19. (a) OCT 3 1945 (b) J. J. Brebeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 28th day October
year 1945 hour 6:05 minute Am 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 _____
Cerebral Hemorrhage

Due to _____
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?
(Specify type of place)

While at work _____ (e) Means of injury _____
23. Signature Patricia E. Jugh (M. D. or other)
Address 1047 W. ... Date signed 10/3/45

(Licensed Embalmer's Statement on Reverse Side)

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

65070

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..... *Homer W. Jutz*

Licensed Embalmer No. *3882*

P. O. Address.....

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.