

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21751

State File No. 5529

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN ST. LOUIS MO)		c. LENGTH OF STAY (in this place) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3973 ^a DOVER PL		d. STREET ADDRESS (If rural, give location) 3973 ^a DOVER PL.	
3. NAME OF DECEASED (Type or Print) a. (First) STEPHAN		b. (Middle) -	
c. (Last) SUM		4. DATE OF DEATH (Month) (Day) (Year) JUNE 26 1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH DEC. 22 1865
9. AGE (In years last birthday) 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COOPER	11. BIRTHPLACE (State or foreign country) GERMANY 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME STEPHAN SUM		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARGARETHE SUM
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS CARL SUM 3973 ^a DOVER PL.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (Right side) ANTECEDENT CAUSES DUE TO (b) Chronic Arteriosclerosis DUE TO (c) and Chronic Nephritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION no	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 48 yrs. 1 yr.	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 23rd, 1949, to June 26, 1949, that I last saw the deceased alive on June 25, 1949, and that death occurred at 11:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) M. A. Walter M.D.		23b. ADDRESS 3608 S. Grand Blvd.,	
23c. DATE SIGNED 6/27/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JUNE 28 1949	
24c. NAME OF CEMETERY OR CREMATORY RESURRECTION		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 27 1949 J. J. S. S. S.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gravois	

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed _____

James C. Hill

Licensed Embalmer No. _____

4347

P. O. Address _____

2906 Drive

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.