

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14778

State File No. 4128

FILED MAY 12 1951

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>4128</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				2. STREET ADDRESS (If rural, give location) <u>3142 Lawton Blvd.</u>			
3. NAME OF DECEASED a. (First) <u>Hazel</u> b. (Middle) _____ c. (Last) <u>Stenson</u>			4. DATE OF DEATH (Month) <u>April</u> (Day) <u>27</u> (Year) <u>1951</u>				
5. SEX <u>3</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>married</u>	8. DATE OF BIRTH <u>3-16-1883</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work, giving most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Madisonville Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ike McNeary</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Brooks</u>		14. NAME OF HUSBAND OR WIFE <u>Doc Stenson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war & date of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Doc Stenson</u> ADDRESS <u>3142 Lawton Blvd</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>				<u>Undet.</u>	
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Undetermined</u> DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>322X</u>			
22. I hereby certify that I attended the deceased from <u>4-8</u> <u>1951</u> , to <u>4-27</u> , <u>1951</u> ; that I last saw the deceased alive on <u>4-27</u> , <u>1951</u> , and that death occurred at <u>11:10 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Carroll W. Harris</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>2601 N Whittier</u>		23c. DATE SIGNED <u>4-30-51</u>	
24a. BURIAL, CREMATION (REMOVAL) <u>Madisonville Ky.</u>		24b. DATE <u>May 2-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Town Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Madisonville Ky.</u>	
DATE REC'D BY LOCAL REG. <u>MAY 1 1951</u>		REGISTRAR'S SIGNATURE <u>X. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gushowe</u> ADDRESS <u>2930 Dickson St.</u>			

WRITE PLAINLY—USING UNFADEING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Leroy W. Bannister

Signed.....
Student Embalmer

Licensed Embalmer No. *4523*

P. O. Address *3880 Easton Ave*

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.