

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25867

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1669

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>University City</u> d. Is Residency within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) <u>3 Days</u>		e. STREET ADDRESS (If rural, give location) <u>633 West Canterbury Rd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Remy</u>	b. (Middle) <u>E.</u>	c. (Last) <u>Stoffel</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>7 12 54</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/7/1886</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief Druggist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Drug</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Remy J. Stoffel</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Green</u>	14. NAME OF HUSBAND OR WIFE <u>The Late Blanche Stoffel</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If you give war or dates of service) <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Remy Stoffel</u> ADDRESS <u>633 W. Canterbury Rd.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Disturbed Cerebral Circulation (perforated - vascular accident)</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac - Renal Disease</u> DUE TO (c) <u>with Compensative Heart Failure</u>		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from June, 1954 to July 11, 1954, that I last saw the deceased alive on July 12, 1954, and that death occurred at 9:12 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr. 2</u>	23b. ADDRESS <u>2335 Brown Orchard</u>	23c. DATE SIGNED <u>7-12-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 14 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>7/13/54</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	5. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Collier Mortuary 10123 St. Chas. Rd.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNEADING BLACK INK--MAKE A PERMANENT RECORD

No. 300  
10.48001  
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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 *Sheldon Collier*.....

Licensed Embalmer No. *338*.....

P. O. Address *1012387*.....

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.