

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35196**  
**9179**

FILED NOV 15 1955  
BIRTH NO. **13612-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

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|---|--|--|--|
| 1. PLACE OF DEATH (Where deceased lived. If institution: residence before admission).<br>a. COUNTY <b>Jackson Desloge Hosp.</b> |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b><br>b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>  | c. LENGTH OF STAY (in this place)<br><b>4 days</b> | c. CITY OR TOWN<br><b>St. Louis</b>  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>2069</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Jirmin Desloge Hosp</b>   |  | STREET ADDRESS (If rural, give location)<br><b>62315 Howard St. St Louis 6</b>   |  |

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|--|---|---|--|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Dennis</b><br>b. (Middle) <b>Michael</b><br>c. (Last) <b>Stephenson</b> | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Oct 20 1955</b> |   |  |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W.</b>                               | 7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-16-1915</b>      | 9. AGE (In years last birthday) Months Days Hours Min.<br><b>40</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>                   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>            | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Jirmin Desloge Mo 510</b>            | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   |

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|--|---|---|
| 13a. FATHER'S NAME<br><b>Harry A. Stephenson</b>   | 13b. MOTHER'S MAIDEN NAME<br><b>Marion Lawson</b> | 14. NAME OF HUSBAND OR WIFE<br>_____  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO.                           | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Harry Stephenson 2315 Howard Street</b> |

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|---|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b>                                |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Intra-cranial hemorrhage</b>   |   |  |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |   |  |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION<br><b>O.K. Joseph M. Quinn Deputy Coroner 10/24/55</b>  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)<br><b>3314 7600</b> |  |
| 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?  |  |

22. I hereby certify that I attended the deceased from **10-16, 1955**, to **10-20, 1955**, that I last saw the deceased alive on **10-20, 1955**, and that death occurred at **12:15 a.m.**, from the causes and on the date stated above.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 23a. SIGNATURE<br><b>Thomas K. Erlite M.D.</b>             | (Degree or title)                | 23b. ADDRESS<br><b>1325 So Grand</b>                          | 23c. DATE SIGNED<br><b>10-20-55</b>                                     |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 24b. DATE<br><b>Oct. 22/1955</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b> | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.,</b> |

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|--|---|---|
| DATE REC'D BY LOCAL REG.<br><b>OCT 21 1955</b> | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith, M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Liedner Und., Co. 2223 St. Louis Ave.,</b> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Robert M Murray*

Licensed Embalmer No. *31*

P. O. Address *St Louis*

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.