

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15324

FILED MAY - 8 1957

State File No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 4014

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 4 mo.		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hosp.		e. STREET ADDRESS (If rural, give location) 270 5854 Rhodes Ave.	
3. NAME OF DECEASED (Type or Print) Gladys		4. DATE OF DEATH (Month) 4 (Day) 24 (Year) 1957	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 11, 1918	
9. AGE (In years last birthday) 38		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Geo. Wiesehan		13b. MOTHER'S MAIDEN NAME Ida Walton	
14. NAME OF HUSBAND OR WIFE Clarence Stein			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Clarence Stein		ADDRESS 5854 Rhodes Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Bronchopneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
*This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Multiple Sclerosis</i>		10 1/2 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 491x	
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) (Min.)		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 12-10-56, 19___, to 4-24-57, 19___, that I last saw the deceased alive on 4-24-57, 19___, and that death occurred at 12:45 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		23b. ADDRESS 5800 Arsenal St.	
23c. DATE SIGNED 4/25/57			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 27, 1957	
24c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. APR 26 57		REGISTRAR'S SIGNATURE <i>Carl Smith</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Kriegshauser</i>		ADDRESS 4228 S. Kingshighway Bl.	

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 *Richard W. Stevenson*.....

Licensed Embalmer No. 4007

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.