

FILED SEP 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH30067  
STATE FILE NUMBER 7677

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hosp.</b>		Length of stay in 1b	d. STREET ADDRESS <b>2907 Salena</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>M.</b> Last <b>STYLES</b>			4. DATE OF DEATH Month <b>8</b> Day <b>14</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-15-1875</b>	9. AGE (In years last birthday) <b>81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Saul Styles</b>			14. MOTHER'S MAIDEN NAME <b>Martha Pagehall</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>494-01-3601</b>	17. INFORMANT Address <b>Lester Styles, 2907 Salena</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					?
DUE TO (c) <b>CONGESTIVE HEART FAILURE ACUTE</b>					<b>6 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>420.0</b>		
20c. TIME OF INJURY Hour <b>3:55</b> Month <b>8</b> Day <b>14</b> Year <b>1957</b> a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>		STATE <b>Missouri</b>
21. I attended the deceased from <b>May 26, 1957</b> to <b>8-14-57</b> and last saw her alive on <b>Aug 14, 1957</b> Death occurred at <b>3:55 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter M. Foreman M.D.</b>			22b. ADDRESS <b>457 N. Kingshighway, St. Louis,</b>		22c. DATE SIGNED <b>8/15/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-17-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>McLAUGHLIN'S, 2301 Lafayette</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 16 57</b>	26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Colorer cannot certify to accuracy of information unless colorer is personally related. Diseases in Part I must be causally related.

457 N K  
D. LANGERN

39, Louisiana

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *A. G. Farris*

Licensed Embalmer No. *3*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.