

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

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42653
State File No. 11199
Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 3 wks.		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 23 St. John's Hospital				e. STREET ADDRESS (If rural, give location) 4912 4515 Laclede Ave.							
3. NAME OF DECEASED (Type or Print) a. (First) Mabel			b. (Middle) Stanley			c. (Last)					
4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1957											
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH July 21, 1885					
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months 4		IF UNDER 24 HRS. Days 0		Hours 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-at home			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri					
12. CITIZEN OF WHAT COUNTRY? U.S.											
13a. FATHER'S NAME Pierre Ahearn			13b. MOTHER'S MAIDEN NAME Catherine Brennan			14. NAME OF HUSBAND OR WIFE Charles J. Stanley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Kathryn Timmerman, 3548 Victor Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION							
<p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u></p> <p>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u></p> <p>DUE TO (c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>3317</u></p>											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
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) (m.)		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 <u>1954</u> , <u>19</u> , to <u>11/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>57</u> , and that death occurred at <u>5:45 A.M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>John J. Donnelly M.D.</u>				23b. ADDRESS <u>16 Houghton Village Plaza</u>		23c. DATE SIGNED <u>11-22-57</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 23, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>					
DATE REC'D BY LOCAL REG. <u>NOV 22 57</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Donnelly 3840 Lindell Blvd.</u>							

WRITE PLAINLY—USING UNFADING 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 Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *James Williamson*

Licensed Embalmer No. *3565*
P. O. Address *3840 Linden*

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.