

t. Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038258
STATE FILE NUMBER

FILED NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10055

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N Grand St Louis Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 35 Vets Admin Hospital		Length of stay in 1b 6 Days	d. STREET ADDRESS 4452 Cottage Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle H. Last Stapp			4. DATE OF DEATH Oct 17 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/95		9. AGE (In years last birthday) 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter (Retired)		10b. KIND OF BUSINESS OR INDUSTRY General Motors		11. BIRTHPLACE (City and state or country) Cairo, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John D. Stapp		13b. MOTHER'S MAIDEN NAME Josie Allen	
14. NAME OF HUSBAND OR WIFE Alberta Stapp		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 493 05 6669	
17. INFORMANT VA Hosp Records		Address 915 N Grand St Louis, Mo.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) 450.0	
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"/>		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.)		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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		COUNTY STATE	
21. VA attended the deceased from 10/11/58 to 10/17/58 and last saw him alive on 10/17/58 Death occurred at 1:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Robt. E. Stappleton M.D. (Degree or title)		22b. ADDRESS M.D. VAH, St. Louis, Missouri,	
22c. DATE SIGNED 10/17/58		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/22/58	
23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) Jefferson Barracks, Mo.		(State)	
24. FUNERAL DIRECTOR Charles J. Gates		ADDRESS 4107 Finney		25. DATE RECD. BY LOCAL REG. OCT 2 1958	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.					

(Licensed Embalmer's Statement on Reverse Side)

m. j. b.

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 *Lawrence E. Woodson*

Licensed Embalmer No. *4341*
P. O. Address *4107 Finney Ave*

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.