

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042661

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

FILED NOV 17 1958 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2754

300  
1-56

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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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Conord Village</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hosp.</u>		Length of stay in 1b <u>DOA</u>	d. STREET ADDRESS (If outside, give location) <u>9811 Geraald Dr</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> <u>G.</u> <u>Stolle</u>			4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26 1892</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Orchard Paper Co.</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Stoble</u>			14. MOTHER'S MAIDEN NAME <u>Mary Oenderfer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>487-20-8913</u>	17. INFORMANT <u>Mr William Stolle</u> Address <u>Rt 14 Box 522 Affton 23 Mo.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>331X</u>					
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 _____ 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		COUNTY _____ STATE _____
21. I attended the deceased from <u>Jan 1948</u> , to <u>Oct. 25 1958</u> and last saw <u>him</u> alive on <u>Oct 25 1958</u> . Death occurred at <u>11:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert W. Tichenor MD</u> (Degree or title)			22b. ADDRESS <u>P.O. Box 6 Springton 23 Mo</u>		22c. DATE SIGNED <u>10/27/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 28 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Our Redeemer Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Affton Mo.</u>	
24. FUNERAL DIRECTOR <u>Fey Funeral Home, Mehlville Mo.</u>		ADDRESS <u>10-28-58</u>	25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Herbert R. Dombey MD</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *W E Morris*.....

Licensed Embalmer No. *33*.....

P. O. Address *St Lou*.....

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