

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011420
STATE FILE NUMBER

1921

300
1-57
38
3P
151

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

MAR 18 1959

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY **St. Louis**

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo.** Inside Limits Yes No

c. CITY OR TOWN **Pine Lawn 4151** Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **Veterans Hospital** Length of stay in lb **DOA**

d. STREET ADDRESS (If outside, give location) **4019 Beachwood** Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
Calvin J. Stephenson

4. DATE OF DEATH Month Day Year
Feb. 23, 1959

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH **March 6, 1898** 9. AGE (In years last birthday) **60** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired Electrician** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and state or country) **Roscoe, Missouri.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Joseph Stephenson** 13b. MOTHER'S MAIDEN NAME **Flora James** 14. NAME OF HUSBAND OR WIFE **Johanna**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **Yes W.W.#1** 16. SOCIAL SECURITY NO. **494-07-0802** 17. INFORMANT Address **Johanna Stephenson, 4019 Beachwood, Pine Lawn 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) **Arteriosclerotic Heart Disease**
DUE TO (b) **Arteriosclerosis**
DUE TO (c) **420.0**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____

20f. CITY, TOWN, OR LOCATION COUNTY STATE
Jefferson Barracks, Mo.

21. I attended the deceased from _____ to _____ and last saw her alive on _____
Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree of) _____ 22b. ADDRESS **1300 Cash** 22c. DATE SIGNED **2/24/59**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **2-26-59** 23c. NAME OF CEMETERY OR CREMATORY **National Cemetery** 23d. LOCATION (City, town, or county) (State) **Jefferson Barracks, Mo.**

24. FUNERAL DIRECTOR ADDRESS **Fanner Funeral Home, 6107 Natural Bridge** 25. DATE RECD. BY LOCAL REG. **FEB 24 '59** REGISTRAR'S SIGNATURE **Carol Smith, M.D.**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Elton H. Rinehart

Licensed Embalmer No. 4283

P. O. Address St. Louis Mo.

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.