

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011434

STATE FILE NUMBER  
2588

MAR 27 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3940 Hartford</u>		Length of stay in 1b	d. STREET ADDRESS <u>3940 Hartford</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>-</u> Last <u>Stueck</u>			4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1875</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10. USUAL OCCUPATION (Give kind of work done during last 12 months, if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
<u>Metel Worker</u>	<u>None</u>	<u>Germany</u>	<u>U.S.A.</u>

13a. FATHER'S NAME <u>Reinhardt Stueck</u>	13b. MOTHER'S MAIDEN NAME <u>Inhana Beck</u>	14. NAME OF HUSBAND OR WIFE <u>Etta Wagner Stueck</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-36-5741</u>	17. INFORMANT <u>Etta Stueck</u> Address <u>3940 Hartford</u>
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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 Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>332X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Inguinal hernia</u>		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.)
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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
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21. I attended the deceased from Death occurred at <u>5 AM</u> on <u>3-8-59</u> to <u>3-11-59</u> and last saw him alive on <u>3-6-59</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Eugene H. Edde M.D.</u>	22b. ADDRESS <u>4971 Chippewa St.</u>	22c. DATE SIGNED <u>3-13-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Removed</u>	<u>3-14-1959</u>	<u>New St. Marcos, Mo.</u>	<u>St. Louis, Mo.</u>

24. FUNERAL DIRECTOR <u>Mr. Vermelle</u> ADDRESS <u>3819 So Grand St.</u>	25. DATE RECD. BY LOCAL REG. <u>MAR 13 '59</u>	26. REGISTRAR'S SIGNATURE <u>Grant Smith, M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

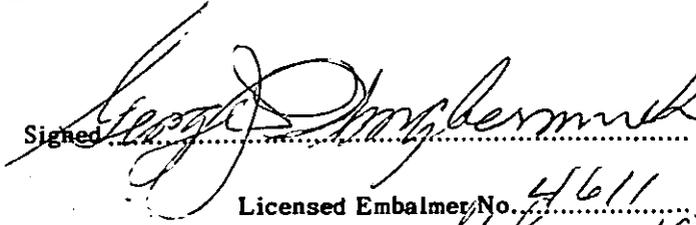
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

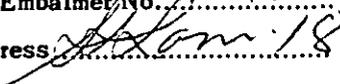
STATEMENT BY LICENSED EMBALMER

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  .....

Licensed Embalmer No. 4611 .....

P. O. Address  .....

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.