

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027660

FILED VS JUL 22 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1832 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fenton</u>	Length of stay in 1b <u>1 Yr.</u>	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fieser Nursing Home</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <u>5636 Theodosa</u>
		Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

3. NAME OF DECEASED (Type or print) First <u>Delia</u> Middle <u>A.</u> Last <u>Chevalier</u>			4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1959</u>			
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5. SEX <u>Female</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>4/14/1863</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
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13a. FATHER'S NAME <u>Thomas Stanton</u>		13b. MOTHER'S MAIDEN NAME <u>Bridget Moran</u>		14. NAME OF HUSBAND OR WIFE <u>late-Adelard Chevalier</u>			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>489-16-9320 D</u>	17. INFORMANT Address <u>Jennie Veynon St. Louis</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:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>						<u>10 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>							
DUE TO (c) <u>Generalized Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

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 <u> </u> Month, Day, Year <u> </u> 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 <u>July 1958</u> to <u>July 7-59</u> and last saw her <u> </u> live on <u>July 5-1959</u> Death occurred at <u> </u> 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>Frank Huck M.D.</u>				22b. ADDRESS <u>Fenton, Mo.</u>				22c. DATE SIGNED <u>7/8/59</u>		
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/9/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>		
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24. FUNERAL DIRECTOR ADDRESS <u>Leoff, Fieser, Fenton Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>7-8-59</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy, MD</u>			
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Gerald J. Mah...

Licensed Embalmer No. 4975

P. O. Address De Soto,

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