

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 27 1959

59-030823

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7633** STATE FILE NUMBER

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 St. Louis, Mo.	Length of stay in 1b 1 Yr. 11 Mo. 6	c. CITY OR TOWN St. Louis,	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp.	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2810 Magnolia	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Mathilda	First	Middle	Last	4. DATE OF DEATH Month August Day 15 Year 1959.
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH SEPT 16 1863	9. AGE (last birthday) 95	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) BELLEVILLE 166.	12. CITIZEN OF WHAT COUNTRY U-S-A
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13a. FATHER'S NAME Wm. Branch	13b. MOTHER'S MAIDEN NAME Elizabeth Smith.	14. NAME OF HUSBAND OR WIFE FRANK C. STETZNER (DEC'D)
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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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MRS. EDW. MADIGAN 2810 MAGNOLIA
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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) Chronic Basilar Congestion of Heart		4 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic Heart Disease	23 mo.
	DUE TO (c) Generalized Arteriosclerosis	23 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0		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 _____ a.m. _____ p.m. Month, Day, Year _____	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 September 5, 1957 , to August 15, 1959 and last saw her/him alive on August 15, 1959. Death occurred at 2:15 A.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) John W. Beckham, M.D.	22b. ADDRESS 5800 Pershing	22c. DATE SIGNED 8/15/59 (State)
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23. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE AUG 18 1959	23c. NAME OF CEMETERY OR CREMATORY WALNUT HILL CEM.	23d. LOCATION (City, town, or county) BELLEVILLE 166.
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24. GENERAL DIRECTOR ADDRESS Thomas Kutis 2906 GRAVOIS	25. DATE RECD. BY LOCAL REG. AUG 17 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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

James O. Bell

Licensed Embalmer No. 4347

P. O. Address 2906 D.

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.