URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–034713

FILED VS SEP 16 1959

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2417

STATE FILE NUMBER

ENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Webster Groves
Length of stay in 1b: At home
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 424 Spring Ave.
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Webster Groves
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 424 Spring
Reside on Farm: Yes [ ] No [✓]

3. NAME OF DECEASED (Type or print): First: MARGARET Middle: AGNEW Last: STACY

4. DATE OF DEATH: Month: Sept. Day: 7 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 1873-74

9. AGE (last birthday): 85

IF UNDER 1 YEAR: Months: Days:

IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (City and state or country): Chicago, Ill.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John McKendrick

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Theodore E. Stacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: John McKay, Address: 424 Spring Ave.

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)	Carcinoma of glands of mesentery	sick
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO~~ (b)	Also Infarct (old) of heart	2 mos
~~DUE TO~~ (c)	Also Diverticulae of colon	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Cirrhosis of liver & enlargement.

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

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 a.m. p.m. Month, Day, Year: None

20d. INJURY OCCURRED WHILE AT WORK [ ] 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

21. I attended the deceased from two months, to 9/7/59 and last saw her alive on 9/7/59

Death occurred at 7 am. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Frank P. Gaunt (Degree or title) MD.

22b. ADDRESS: 13 N. Gore Webster Groves Mo.

22c. DATE SIGNED: 9/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: 9-9-59

23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory

23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR ADDRESS: Parker-Aldrich, Webster Groves

25. DATE RECD. BY LOCAL REG.: 9-9-59

26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(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_____ Signed Leslie Walch

Signature of Student Embalmer

Licensed Embalmer No. 4395

P. O. Address Webster Grov

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