

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038119**

**FILED VS NOV 3 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9774**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 days</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Johns Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>5918 Garesche Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>STIERMANN</b> Last				4. DATE OF DEATH Month <b>Oct.</b> Day <b>22</b> Year <b>1959</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8/1/1880</b>		9. AGE (last birthday) <b>79</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <b>streetcar operator</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Public Service</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Wm. Stiermann</b>			13b. MOTHER'S MAIDEN NAME <b>Gertrude Lepping</b>			14. NAME OF HUSBAND OR WIFE <b>Amelia Stiermann</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>193 10 9294</b>		17. INFORMANT Address <b>Amelia Stiermann 5918 Garesche Ave.</b>				
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertensive cardiovascular disease</b>									
DUE TO (c) <b>443x</b>									
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 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.)					
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	
21. I attended the deceased from <b>Oct. 18 - 1959</b> to <b>Oct. 22 - 1959</b> and last saw her/him alive on <b>Oct. 22 - 59</b> Death occurred at <b>8:45 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Erin Bernhardt M.D.</b> (Degree or title)				22b. ADDRESS <b>18 S. Kingshighway St. Louis Mo</b>		22c. DATE SIGNED <b>Oct-23-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/26/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Buchholz Mortuary 5967 W. Florissant</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 26 1959</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*E.P.*

**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 Walter A. Beckwith

Licensed Embalmer No. 4551

P. O. Address St. Louis

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.