

**DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

59-038347

FILED VS NOV 16 1959 317

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2874

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>St. Louis</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>St. Louis</b>	b. COUNTY <b>St. Louis</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kirkwood</b>	Length of stay in 1b <b>4 years</b>	c. CITY OR TOWN <b>Kirkwood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2441 St. Giles Rd.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>2441 St. Giles Rd.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>A.</b>	Last <b>STURDY</b>	4. DATE OF DEATH	Month <b>Oct.</b>	Day <b>27</b>	Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/69</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Valley Park, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Frederick Sanders</b>	13b. MOTHER'S MAIDEN NAME <b>Marguerite Striffler</b>	14. NAME OF HUSBAND OR WIFE <b>John O. Sturdy</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Emma S. Wetterer, 2441 St. Giles, Kirkwood Mo.</b>
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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) <b>Arteriosclerotic Heart Disease</b>	<b>year</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b>	<b>year</b>
DUE TO (c)	

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
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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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year
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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 10/23/59 to 10/27/59 and last saw her alive on 10/27/59  
Death occurred at 2:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Sam F. Bean M.D.</b> (Degree or title)	22b. ADDRESS <b>35 N. Central - St. Louis 17 Mo.</b>	22c. DATE SIGNED <b>10/29/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>10/29/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b> (State)
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24. FUNERAL DIRECTOR <b>Louis A. Propp, Inc. Kirkwood</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>10-29-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Francis J. [Signature]*

Licensed Embalmer No. 4572

P. O. Address Richardson

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.