URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

[redacted]

ENDED

FILED VS MAR 7 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2040

STATE FILE NUMBER 60-008915

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: FIRMIN DESLOGE
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 4353 BECK
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EMIL Middle N. Last STEHLIK

4. DATE OF DEATH: Month Feb Day 18 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 4-30-1912

9. AGE (last birthday): 47

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): BUILDING CLEANER

10b. KIND OF BUSINESS OR INDUSTRY: DAVIS CO.

11. BIRTHPLACE (City and state or country): Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: PETER STEHLIK

13b. MOTHER'S MAIDEN NAME: ELIZABETH MALY

14. NAME OF ~~HUSBAND~~ OR WIFE: ANNA STEHLIK

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.

17. INFORMANT: ANNA STEHLIK Address: 4353 BECK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Coronary Arteriosclerosis
DUE TO (c): 420.1

INTERVAL BETWEEN ONSET AND DEATH

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. ☐ 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

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 1-67 to 2-17-60 and last saw ~~him~~ him alive on 2-17-60

Death occurred at 12 41 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Cornelius J. O'Connor, M.D.

22b. ADDRESS: 1325 S. Grand. Bl.

22c. DATE SIGNED: 2-20-60

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

23b. DATE: Feb 22, 1960

23c. NAME OF CEMETERY OR CREMATORY: RESURRECTION CEM

23d. LOCATION (City, town, or county): ST. LOUIS (State): Mo.

24. FUNERAL DIRECTOR: Thomas Kuhs ADDRESS: 2906 Gravois

25. DATE RECD. BY LOCAL REG.: FEB 21 1960

26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 _____ Signed Elena Brown

Signature of Student Embalmer

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

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