

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1960

=60-036592

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9588 STATE FILE NUMBER

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|--|--|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u> | | Length of stay in 1b <u>LIFE.</u> | | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>320 N. Union Blvd</u> | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>320 N. Union</u> | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>PHINEAS</u> Middle <u>DAVID</u> Last <u>STAHL</u> DATE OF DEATH <u>Phineas David Stahl</u> <u>10</u> <u>9</u> <u>1960</u> | | | | | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/17/99</u> | |
| 9. AGE (last birthday) <u>61</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor of Medicine</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Harry Stahl</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mae Jacks</u> | | 14. NAME OF HUSBAND OR WIFE <u>Norma C. Stahl</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>2 ndWW</u> | | 16. SOCIAL SECURITY NO. <u>388-16-4210</u> | | 17. INFORMANT Address <u>Norma C. Stahl 320 N. Union Blvd</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> DUE TO (b) <u>Coronary Thrombosis</u> " DUE TO (c) <u>Coronary Sclerosis</u> " PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> 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 <u>April 1955</u> to <u>Oct 2/60</u> and last saw him alive on <u>10/2/60</u> Death occurred at <u>6:50 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>W. H. Smith, M.D.</u> | | | | 22b. ADDRESS <u>3790 Washington</u> | | 22c. DATE SIGNED <u>10/2/60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> | | 23b. DATE <u>10/3/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Olive</u> | | 23d. LOCATION (City, town, or county) (State) <u>NORTH & SOUTH ROAD St. Louis Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Mayer</u> | | ADDRESS <u>4356 Lindell Blvd</u> | | 25. DATE RECD. BY LOCAL REG. <u>OCT 3 1960</u> | | 26. REGISTRAR'S SIGNATURE <u>W. H. Smith, M.D.</u> | |

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 J W B Embler

Licensed Embalmer No. 365

P. O. Address St Louis

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