

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048377

FILED VS JAN 9 1961 317 Registration District No. 500 Primary Registration District No. 3710 REGISTRAR'S No. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis City</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch, Mo</u>		Length of stay in 1b <u>523 days</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>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2609 South Grand</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>(none)</u> Last <u>Stett</u>			4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>60</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-18-74</u>	9. AGE (last birthday) <u>86 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Charles Stett</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Saunders</u>	14. NAME OF HUSBAND OR WIFE <u>Gertrude Meek</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>(?)</u>	17. INFORMANT <u>Koch Hosp. Records, Koch, Mo.</u> Address
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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: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>		<u>(?) Years</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>		<u>(?) Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Tuberculosis</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 <u>9:30</u> Month, Day, Year <u>7-17-59</u> a.m. p.m.	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 7-17-59 to 12-22-60 and last saw <sup>him</sup> ~~her~~ alive on 12-22-60  
Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H.A. Harris</u> (Degree or title) <u>H.A. Harris MD</u>	22b. ADDRESS <u>Rob't Koch Hosp, Koch, Mo</u>	22c. DATE SIGNED <u>12-23-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>C.R. Lupton &amp; Sons</u> ADDRESS <u>7233 DELMAR</u>	25. DATE RECD. BY LOCAL REG. <u>12-24-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address H. Lewis

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.