SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-012136
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 839

FILED APR 10 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ellisville, Mo.
Length of stay in 1b: 5 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunset Sanitarium
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Dellwood
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 10845 West Florissant Ave
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: EDWIN Middle: S. Last: STAEHLE
4. DATE OF DEATH Month: March Day: 25 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 5-2-1898
9. AGE (last birthday): 62
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): ?
10b. KIND OF BUSINESS OR INDUSTRY: Unemployed
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Louis Staehle
13b. MOTHER'S MAIDEN NAME: Martha Becker
14. NAME OF HUSBAND OR WIFE: Mrs Violet Staehle (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
17. INFORMANT: Address: Mr Roy Hagedorn, 10845 W. Florissant, Ave

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) Bilateral Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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): Cerebro-arteriosclerosis; Parkinsonism
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 March 23, 1961, to March 25, 1961 and last saw him alive on March 24, 1961
Death occurred at 10:40 A.m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE George E. Smith (Degree or title) M.D.
22b. ADDRESS 325 N. Kirkwood Rd. Kirkwood 22 Mo.
22c. DATE SIGNED 3/25/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3-28-1961
23c. NAME OF CEMETERY OR CREMATORY: Friedens Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS: Math. Hermann & Son Inc. 2161 E. Fair Ave.
25. DATE RECD. BY LOCAL REG.: 3-28-61
26. REGISTRAR'S SIGNATURE: John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

MS APR 10 1981

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 Clement McNea

Licensed Embalmer No. 3732

P. O. Address St. Louis

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