

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023205

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5667 STATE FILE NUMBER

FILED JUN 29 1961

DATE AMENDED

INSIDE OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		c. CITY OR TOWN <u>East St. Louis</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>431 N. 19th Street</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>H.</u> Last <u>STANKEY</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1961</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
-----------------------	----------------------------------	---	---	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Inspector</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Dept of Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Columbia, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	--	---	--

13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Grace Turner Stankey</u>
--------------------------------------	---	--

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>None</u>	17. INFORMANT <u>Grace Stankey, 431 N. 19th St., E. ST. Louis</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>RETICULUM CELL SARCOMA OF RETROPERITONEAL AREA WITH METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>2000</u>		

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 type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 4, 1961</u> to <u>JUNE 16, 1961</u> and last saw her/him alive on <u>JUNE 16, 1961</u> Death occurred at <u>8:55 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <u>F. R. BRADLEY, M. D.</u>	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>6/16/61</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 19, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <u>KURRUS FUNERAL HOME, E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 17 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>
--	--	---

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 \_\_\_\_\_

*[Handwritten Signature]*

Licensed Embalmer No. 3162

P. O. Address E. St Louis

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.