

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023604

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1624

FILED JUN 21 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>St. Louis</u>				a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Heights</u>		Length of stay in lb <u>1 week</u>		c. CITY OR TOWN <u>Oakland</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>St. Marys Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>800 E. Monroe</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		
<u>MARY</u>			<u>VIRGINIA</u>	<u>STEIN</u>	<u>June 10, 1961</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-13-1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired Nun (Religious)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ursuline Acad.</u>		11. BIRTHPLACE (City and state or country) <u>Shattuc, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		
13a. FATHER'S NAME <u>Xavier Stein</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Catherine Adams</u>			14. NAME OF HUSBAND OR WIFE <u>None</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>Oakland, Missouri</u> <u>Ursuline Convent-800 E. Monroe</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>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input 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>1242</u> to <u>June 10, 1961</u> and last saw her alive on <u>June 10, 1961</u> Death occurred at <u>8:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>E. J. Roehner M.D.</u>				22b. ADDRESS <u>8787 Big Bend</u>			22c. DATE SIGNED <u>6/10/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6-12-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		23d. LOCATION (City, town, or county) <u>Kirkwood Mo.</u>			
24. FUNERAL DIRECTOR <u>Pfitzinger Mort-Kirkwood 22, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>6-10-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Bene A. Williams

Licensed Embalmer No. 1890

P. O. Address 366

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.