ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-035477
STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 5411 Registrar's No. 2784

FILED OCT 9 1961

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION DOA St. Louis Co. Hosp. — Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Maplewood — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 2001 Bellevue — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First EMMA Middle KRISTINE Last STIGALL
4. DATE OF DEATH Month October Day 1 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH May 3, 1883
9. AGE (last birthday) 78
IF UNDER 1 YEAR: Months 4 Days 29 — IF UNDER 24 HR: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Mathieson
13b. MOTHER'S MAIDEN NAME Laura Khroist
14. NAME OF HUSBAND OR WIFE Sam Little Stigall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT C. W. Mathieson, Sedalia, Missouri

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) Angina pectoris — INTERVAL BETWEEN ONSET AND DEATH 1/2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease ?
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. ☐ 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 Dec 30 48, to Sept 30 61 and last saw her/him alive on Sept 15 61
Death occurred at 11 pm (approximate) on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Samuel B Grant MD (Degree or title)
22b. ADDRESS 114 N Taylor Ave
22c. DATE SIGNED 10-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct. 3, 1961
23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery
23d. LOCATION (City, town, or county) St. Louis County, Missouri (State)

24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd. ADDRESS
25. DATE REC'D BY LOCAL REG. 10-3-61
26. REGISTRAR'S SIGNATURE John C. Mangley M.D.

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF DOCUMENT

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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4788

P. O. Address _____

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.