

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039253
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10014

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b	c. CITY OR TOWN <u>ST. LOUIS</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1514 LAFAYETTE</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1514 LAFAYETTE</u>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>J.</u> Last <u>STALLINGS</u>	4. DATE OF DEATH Month <u>OCT</u> Day <u>27</u> Year <u>1961</u>
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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>June 28, 1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ELEVATOR OPERATOR</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>INDIANA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ELIJAH STALLINGS</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>BEULAH STALLINGS</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>	17. INFORMANT <u>BEULAH STALLINGS 1514 LAFAYETTE</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>medullary Paralysis</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<u>Coronary Occlusion</u>	
DUE TO (b)	<u>arterio Sclerotic Heart disease</u>	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</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
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 8-19-61 to 10-13-61 and last saw her/him alive on 10-13-61
Death occurred at 835 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Disease or title) <u>W. Scott Kuster M.D.</u>	22b. ADDRESS <u>1829 So 184 St.</u>	22c. DATE SIGNED <u>10-28-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT 30, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO. MO.</u>
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24. FUNERAL DIRECTOR <u>Thomas Kuto 2906 Morris</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 30 1961</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

PR 3-0096
9:00 - 11:00 AM

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 *James C. Hill*

Licensed Embalmer No. 4347
P. O. Address 2906 Dan

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.