

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047408

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3375

STATE FILE NUMBER

AMENDED

FILED DEC 18 1961

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bellefontaine Neighbors | | Length of stay in lb 11 years | c. CITY OR TOWN Bellefontaine Neighbors |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1143 Bluegrass | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1143 Bluegrass |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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| 3. NAME OF DECEASED (Type or print) First ELLA Middle E Last STEALEY | | | 4. DATE OF DEATH Month November Day 27 Year 1961 | | |
|--|--|--|--|--|--|

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|-------------------------|----------------------------------|---|--------------------------------------|---|--|--|
| 5. SEX Female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9/28/1888 | 9. AGE (last birthday) 73 years | 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) housewife | 10b. KIND OF BUSINESS OR INDUSTRY HOME | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
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| 13a. FATHER'S NAME Thomas Harrison | 13b. MOTHER'S MAIDEN NAME Elvina Scheske | 14. NAME OF HUSBAND OR WIFE Eugene Stealey |
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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) No | 17. INFORMANT Bess Berger - 1143 Bluegrass | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Heart Failure | | unknown |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Arteriosclerotic Cardiovascular Disease | unknown |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral arteriosclerosis | 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 |
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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 |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from Oct. 1, 1959 to Nov 27, 1961 and last saw her alive on Nov. 11, 1961
Death occurred at 7:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Leon Birentbaum, M.D. | 22b. ADDRESS 462 N. Taylor St. Louis 8, Mo | 22c. DATE SIGNED 11/28/61 |
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|---|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE Nov 30, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Missouri |
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| 24. FUNERAL DIRECTOR BUCHHODZ MORTUARY-5967 W. Florissant Ave. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 11-28-61 | 26. REGISTRAR'S SIGNATURE John P. Murphy M.D. |
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 W. Fred H. Buchholz

Licensed Embalmer No. 4557

P. O. Address 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.