

1. PLACE OF DEATH a. COUNTY Harris		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Texas b. COUNTY Harris	
b. CITY OR TOWN (If outside city limits, give precinct no.) Houston		c. CITY OR TOWN (If outside city limits, give precinct no.) Houston	
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 4821 Brady Street	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (a) First WILLIAM (b) Middle JENNINGS (c) Last STELLBAUER		4. DATE OF DEATH February 16, 1974	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 20, 1894
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Minutes _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Max Stellbauer	
14. MOTHER'S MAIDEN NAME Annie Marstarno		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.-W. I.	
16. SOCIAL SECURITY NO. Un-available		17. INFORMANT <i>Mrs. Stellbauer</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) TEXAS DEPARTMENT OF HEALTH IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) Metastatic Cancer of Prostate to Bones and Lungs and Bone Marrow DUE TO (c) Surgery for Prostate Cancer		INTERVAL BETWEEN ONSET AND DEATH 2 Hours longer than 2 Ho.
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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)				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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____				
20d. INJURY OCCURRED WHITE AT WORK <input type="checkbox"/> NOT WHITE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I hereby certify that I attended the deceased from 1-30-74 to February 16, 1974 and last saw the deceased alive on 2-16-74. Death occurred at 1:30 P. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>I. H. Mannheim M.D.</i>	22b. ADDRESS 229 2210 Maroneal Houston Texas	22c. DATE SIGNED 2-22-74
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Removal	23b. DATE February 18, 1974	23c. NAME OF CEMETERY OR CREMATORY Bremond Cemetery
23d. LOCATION (City, town, or county) Bremond, Texas	24. FUNERAL DIRECTOR'S SIGNATURE <i>Mark Miller</i> Forest Park Funeral Home 6533	

25a. REGISTRAR'S FILE NO. 01856	25b. DATE REC'D BY LOCAL REGISTRAR FEB. 27 1974	25c. REGISTRAR'S SIGNATURE <i>J.B. Bennett</i>
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MEDICAL CERTIFICATION

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