

No. 2
-10-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16115

Registration District No. 784

Primary Registration District No. 111

State File No. _____

Registrar's No. 905

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-Weeks
(Specify whether years, months or days) 6-Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5567 Waterman Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ year.

8. (a) PRINT FULL NAME Thomas E. Stinson 252

8. (b) If veteran, name war None
8. (c) Social Security No. 489-03-6420

4. Sex M.
5. Color or race W.
6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Katherine Stinson
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased May 2, 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 0 7 hr. min.

9. Birthplace Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Evans & Howard

MOTHER FATHER { 12. Name Unknown Stinson
13. Birthplace Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Almeda Davison
15. Birthplace Ind.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katherine Stinson
(b) Address 5567 Waterman Ave.

17. (a) Removal
(Burial, cremation, or removal) (b) Date thereof 5-10-1940
(Month) (Day) (Year)
(c) Place: burial or cremation Indianapolis, Ind.

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) MAY 9 1940
(Date received local health officer's signature) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9
year 40 hour 12:00 minute 5 P.M.

21. I hereby certify that I attended the deceased from April 30 to May 9, 1940
that I last saw him alive on May 9, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess
Duration _____

Due to Uncertain
Due to _____

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Brain Abscess
Of operations _____
Of autopsy Brain Abscess
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 707

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. W. T. Coughlin (M. D. or other) _____
*Address Dr. W. T. Coughlin

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

75

OFFICIAL

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 _____, Registered Apprentice No. _____ working under my personal supervision.

Signed Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3846 Luella

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16115

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 905

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Rich. Ste.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Thos. E. Strissn

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 54-20 (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9-40 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Brain abscess

Due to # Uncertain #

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 78a

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____ Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Roller

