

No. 2
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2000

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29302**

FILED SEP 8 1941

Registration District No. **784**

Primary Registration District No. **109**

Registrar's No. **1638**

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

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Maplewood**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Maplewood Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **18 months**
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis 96.**
(c) City or town **St. Louis 5**
(If outside city or town limits, write "RURAL")
(d) Street No. **2200 Bedell, Maplewood, M. 5**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **1** years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **3**
year **1941** hour **6** minute **15 A.** M.
21. I hereby certify that I attended the deceased from **Jan 15**, 19**41**, to **Aug 3**, 19**41**
that I last saw her alive on **Aug 1**, 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial infarction
Coronary atherosclerosis
Arteriosclerosis
Due to **Senility**
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations **131**
Of autopsy

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME **Christina Stone**

8. (b) If veteran, name war. 8. (c) Social Security No.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **August P. Stone** 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **March 9 1852**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
89 4 25 hr. min.

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

10. Usual occupation **Hous ewife**

11. Industry or business

12. Name **Johnson**

13. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

14. Maiden name **Johanna**

15. Birthplace **Sweden**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Alma Maurer**

(b) Address **4358 College Avenue**

17. (a) **Burial** (b) Date thereof **Aug. 6 '41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem**

18. (a) Signature of funeral director **Maugh-Tov-Fel**
(b) Address **3402 No. Kingshighway**

19. (a) **AUG 5 - 1941** (b) **E. B. McCarren M.D.**
(Date received local Registrar) (Registrar's signature)

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) (c) Means of injury
23. Signature **E. B. McCarren** (M. D. or other) **M.D.**
Address **4605 W. Flannery** Date signed **8/4/41**

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 *Robert G. Hoyer*.....

Licensed Embalmer No. *2471*.....

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