

FILED MAR 27 1945

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **280**

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2002 No. 2nd. St. !
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 37 Years
years, months or days)

3. (a) PRINT FULL NAME Frank Stoll

3. (b) If veteran, name war None

3. (c) Social Security No. 491-09-9101

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Katherine

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>8</u>	<u>4</u>	hr. _____ min.

9. Birthplace Austria Hungary 4
(City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business Standard Oil Co.

MOTHER FATHER {

12. Name Peter Stoll

13. Birthplace Austria Hungary 4
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Frederick

15. Birthplace Austria Hungary 4
(City, town, or county) (State or foreign country)

16. (a) Informant Katherine Stoll

(b) Address 2002 No. 2nd. St.

17. (a) Burial (b) Date thereof March 10, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nt. Olivet Cemetery

18. (a) Signature of funeral director Herman W. J. deWalden

(b) Address 1802 Union St., St. Joseph, Mo.

19. (a) 3-10-45 (b) Helen J. Gable
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St. Joseph 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2007 No. 2nd. St. 7
(If rural, give location)

(e) Citizen of foreign country? No 1) (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1945 hour 1 minute 00 A.M.

21. I hereby certify that I attended the deceased from 5-5-43 to 3-7-45 P.S.
that I last saw him alive on 3-7 and that death occurred on the date and hour stated above.

Immediate cause of death acute coronary

Due to chronic rheumatoid 5 yrs.

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 9-30

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? _____

(Specify type of place) _____

While at work? _____ (c) Means of injury _____

23. Signature H. W. J. deWalden (M. D. or other) _____
Address Kinspatul Bldg. Date signed 3/10/45

Duration

2 da.

PHYSICIAN

Underline the cause to which death should be charged statistically.

1077

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 *Herwan W. Sidyadaw*

Licensed Embalmer No. *2728*

P. O. Address *Joseph Mo.*

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, fact should be so stated above.