

No. 2
8-13
-1739
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 14 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

11577

State File No.

Registrar's No. **3588**

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1302 S. Compton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days) 95 yrs

3. (a) PRINT FULL NAME CHARLOTT STONE

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

4. Sex Female 5. Color or race Cal 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Drew Stone 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July 16 1895
(Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days 15 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Spiffles Cad Webb

13. Birthplace Byhalia, Miss
(City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Brooks

15. Birthplace Covington, Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant Drew Stone 345 AT

(b) Address 1302 S Compton

17. (a) Burial (b) Date thereof 4-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director J.P. Richards
(b) Address 2625 Blagden

19. (a) APR 4 1948 (b) J.F. Bredeck
(Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000
(c) City or town St Louis (If outside city or town limits, write "RURAL") 1817
(d) Street No. 1302 S. Compton (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23rd
year 1947 hour 7 minutes 45 M.

21. I hereby certify that I attended the deceased from 7th March
1947 to 23rd March
that I last saw h. alive on 31st March 1947
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

Hypertensive Heart Disease 1 year

Due to Disease

Due to.....

Other conditions (Include pregnancy within 3 months of death) 92

Major findings: Of operations.....

Of autopsy no

PHYSICIAN

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?.....

While at work W. W. Beaton (Specify type of place) (e) Means of injury 0

23. Signature W. W. Beaton (M.D. or other)

Address 2743 Franklin (City or town) (State) (Signed)

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

MOTHER, FATHER

APR 21 1987

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 *R.D. Richardson*
Licensed Embalmer No. *2928*
P. O. Address *2625 Glasgow*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 316Primary Registration District No. 1053Registrar's No. 9588

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST. LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (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

3. (a) PRINT FULL NAME

Charlett Stone

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

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced in

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

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

8. AGE: Years 51 Months _____ Days _____ (Less than one day) hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Housewife

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) J. F. Brudeck _____ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

APR 21 1947

11577

2168 of