No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED DEC 6 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 100

State File No. 40214

Registrar's No. 10929

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 095
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1327 Merchant 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME JOSEPH R. STAMP
3. (b) If veteran, name war W. W. I.
3. (c) Social Security No. no
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Alice M. Stamp
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Mar. 5 1900. (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
47	8	23	hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Porter
11. Industry or business
FATHER 12. Name Joseph Stamp.
13. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Catherine Beckley
15. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Alice Stamp
(b) Address 1327 Merchant
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-47 (Month) (Day) (Year)
(c) Place: burial or cremation National Cem
18. (a) Signature of funeral director Witt Bros. L. Mo
(b) Address 2929 S. Jefferson Av.
19. (a) NOV 30 1947 (Date received local registrar) (b) J. F. Breneck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 28th year 1947 hour 7:10 minute P. M.
21. I hereby certify that I attended the deceased from 11/26/47 to Nov. 28th, 1947 that I last saw him alive on Nov. 28th, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Encephalomalacia, left acute severe
Due to: Embolus, left middle cerebral artery
Due to: Rheumatic heart disease
Other conditions (Include pregnancy within 3 months of death): 0
Major findings: Of operations: 0
Of autopsy: As above

Duration

PHYSICIAN
Underline the cause of 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? (Specify type of place) 0
While at work? (e) Means of injury
Signature Warren B. Mills (M. D. or other)
Address 1515 Lafayette Date signed 11/29/47

Jefferson City Printing Co.
(Licensed Embalmer's Statement on Reverse Side)

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

Signed Edgar F. Witt

Licensed Embalmer No. 2117

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, fact should be so stated above.