

No. 2
-12-45
5-17-39
I X47070

UNITED STATES OF AMERICA
STANDARD CERTIFICATE OF DEATH

State File No. **43524**

FILED JAN 9 1948

318

Registration District No. Primary Registration District No.

1003

Registrar's No. **11793**

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:
6247 Clayton Ave.
(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 JOE P. STONE

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

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

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

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

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

About 64 - - hr. - min.

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

10. Usual occupation Tailor

11. Industry or business Joseph Stone

MOTHER FATHER { 12. Name Joseph Stone

{ 13. Birthplace Poland
(City, town, or county) (State or foreign country)

{ 14. Maiden name Unknown

{ 15. Birthplace Poland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joe P. Stone

(b) Address 6247 Clayton Ave.

17. (a) Burial (b) Date thereof 12-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

18. (a) Signature of funeral director Herman Rudolph, Inc

(b) Address 5216 Delmar Blvd

19. (a) DEC 26 1947 (b) J. F. Brodeur
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oas

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 6247 Clayton Avenue 9
(If rural, give location)

(e) Citizen of foreign country? 4 (Yes or No) 0

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25
year 1947 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Aug. 1946 to Dec. 25 1947
that I last saw him alive on Dec. 25 1947
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis heart disease Duration _____

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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)

(e) Means of injury _____

23. Signature W. L. Traud (M. D. or other) _____

Address 637 N. Traud Date signed 12/29/47

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

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.....

John Kettles

Licensed Embalmer No. 3880

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.