

FILED AUG 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22970

State File No. ....

BIRTH NO. .... REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 5381 Registrar's No. 56

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dent</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <u>Mo.</u> b. COUNTY <u>St Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Montauk State Park</u> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Webster Grove</u>  |  |
| c. LENGTH OF STAY (In 24 place)<br><u>1 da</u>  |  | d. STREET ADDRESS (If rural, give location)<br><u>200 Blackmer Place</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>3</u>   |  |   |  |

|                                     |                             |                                |                               |   |
|-------------------------------------|-----------------------------|--------------------------------|-------------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First)<br><u>ROBERT</u> | b. (Middle)<br><u>FLEMMING</u> | c. (Last)<br><u>STONEMAN.</u> | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>JULY 31, 1949</u> |
|-------------------------------------|-----------------------------|--------------------------------|-------------------------------|---|

|                       |                                  |  |                                     |   |                                |                               |
|-----------------------|----------------------------------|--|-------------------------------------|---|--------------------------------|-------------------------------|
| 5. SEX<br><u>MALE</u> | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>1</u> | 8. DATE OF BIRTH<br><u>6-4-1899</u> | 9. AGE (In years last birthday) <u>50</u> | IF UNDER 1 YEAR<br>Months Days | IF UNDER 2 HRS.<br>Hours Min. |
|-----------------------|----------------------------------|--|-------------------------------------|---|--------------------------------|-------------------------------|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Secretary</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u> | 11. BIRTHPLACE (State or foreign country)<br><u>Chicago Ill</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |
|---|---|---|--|

|   |  |   |
|---|--|---|
| 13a. FATHER'S NAME<br><u>Geo Stoneman</u> | 13b. MOTHER'S MARRIAGE NAME<br><u>Cora Fleming</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Virginia Stoneman</u> |
|---|--|---|

|  |   |   |                                 |
|--|---|---|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Yes</u> | 16. SOCIAL SECURITY NO.<br><u>2-1-1-1-1-1-1-1-1-1</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>Virginia Stoneman</u> | ADDRESS<br><u>Webster Grove</u> |
|--|---|---|---------------------------------|

|  |                       |  |                                  |
|--|-----------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><u>My</u> | MEDICAL CERTIFICATION |  | INTERVAL BETWEEN ONSET AND DEATH |
|--|-----------------------|--|----------------------------------|

|   |                  |
|---|------------------|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Angina Pectoris</u> | DUE TO (b) _____ |
|---|------------------|

|                   |                  |
|-------------------|------------------|
| ANTECEDENT CAUSES | DUE TO (c) _____ |
|-------------------|------------------|

|   |              |
|---|--------------|
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. | <u>420 ✓</u> |
|---|--------------|

|                                     |                                  |   |
|-------------------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION<br><u>My</u> | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|-------------------------------------|----------------------------------|---|

|   |  |   |
|---|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)<br><u>My</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|---|--|---|

|   |  |                            |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>✓</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from July 31, 1949, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 2:45 A. m., from the causes and on the date stated above.

|                                     |                   |                                |                                    |
|-------------------------------------|-------------------|--------------------------------|------------------------------------|
| 23a. SIGNATURE<br><u>O. Luskard</u> | (Degree or title) | 23b. ADDRESS<br><u>Looking</u> | 23c. DATE SIGNED<br><u>7-31-49</u> |
|-------------------------------------|-------------------|--------------------------------|------------------------------------|

|   |                             |   |  |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u> | 24b. DATE<br><u>7/31/49</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>St Louis</u> | 24d. LOCATION (City, town, or county) (State)<br><u>Mo</u> |
|---|-----------------------------|---|--|

|   |   |   |   |
|---|---|---|---|
| DATE REC'D BY LOCAL REG.<br><u>Aug 1-49</u> | REGISTRAR'S SIGNATURE<br><u>M.M. Hart</u> | FUNERAL DIRECTOR'S SIGNATURE<br><u>M.D. - 1</u> | ADDRESS<br><u>C.R. Lupton &amp; Sons; 7233 Delmar Blvd;</u> |
|---|---|---|---|

(Licensed Embalmer's Statement on Reverse Side)

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

53  
000S. No. 300  
V. 10.48

RECEIVED 8-8-49  
District Health Officer No. 5,  
District File Number 849558  
Date Filed 8-13-49

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 \_\_\_\_\_

\_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student .....  
Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St Louis, 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.