No. 300
10-48

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32219
Registrar's No. 7862

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH
~~a. COUNTY~~ St. Louis, Mo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 229 West Stein
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 229 West Stein Street

3. NAME OF DECEASED (Type or Print) a. (First) Felician b. (Middle) c. (Last) Stokes

4. DATE OF DEATH (Month) (Day) (Year) Sept 9, 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 28, 1864
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months 5 Days 11 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At. Home
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME ? Boyer
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Elijah Stokes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elijah Stokes 229 West Stein St.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ch. Myocarditis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 97

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4321

22. *I hereby certify that I attended the deceased from* 1945, 19__, *to* 9/9/49, 19__, *that I last saw the deceased alive on* 9-8-, 1949, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W W Eades MD
23b. ADDRESS 1602 S Brody
23c. DATE SIGNED 9/9/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 12,
24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery
24d. LOCATION (City, town, or county) (State) Lemay, Mo.

DATE REC'D BY LOCAL REG. SEP 11 1949
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Undertakin Co 7420 Michigan

(Licensed Embalmer's Statement on Reverse Side)

Inc.

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.

Signed V E Morris

Signed .....
Student Embalmer

Licensed Embalmer No. 3360

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.