

FILED MAY 31 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18860**

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

BIRTH NO. _____		REG. DIST. NO. 3.7		PRIMARY REG. DIST. NO. 3063		Registrar's No. 2249	
1. PLACE OF DEATH a. COUNTY ST CLAYTON MO				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY ST LOUIS CITY			
b. CITY (If outside corporate limits, write RURAL and give township) CLAYTON MO		c. LENGTH OF STAY (In this place) 1 DAY		c. CITY (If outside corporate limits, write RURAL and give township) 61 TOWN A. Webster Groves			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST LOUIS COUNTY				d. STREET ADDRESS (If rural, give location) 902 N. TRUESDALE 4617			
3. NAME OF DECEASED (Type or Print)		a. (First) HARRY		b. (Middle) STOVALL		c. (Last) STOVALL	
4. DATE OF DEATH (Month) (Day) (Year) 5 21 51		5. SEX MALE		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M Sep 1	
8. DATE OF BIRTH Dec 7-1899		9. AGE (In years last birthday) 51		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) University City	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Louis Stovall		13b. MOTHER'S MAIDEN NAME Em Charlotte Emory		14. NAME OF HUSBAND OR WIFE Shaora Stovall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Maureen Mary			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SEVERE PERITONITIS				INTERVAL BETWEEN ONSET AND DEATH 40 hrs	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				40 hrs	
		DUE TO (b) RUPTURED DUODENAL ULCER				20 yrs?	
		DUE TO (c) CHRONIC ALCOHOLISM				3 yrs	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				GENERALIZED ARTERIOSCLEROSIS E ARTERIOSCLEROTIC GANGRENE OF TOES	
19a. DATE OF OPERATION 5-21-51		19b. MAJOR FINDINGS OF OPERATION AS ABOVE				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 5-21, 1951 , to 5-21, 1951 , that I last saw the deceased alive on 5-21, 1951 , and that death occurred at 3:50 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Robert L. P. P. P.				23b. ADDRESS 601 S. Brentwood Clayton MO		23c. DATE SIGNED 5-22-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) BORIAL		24b. DATE 25 MAY 51		24c. NAME OF CEMETERY OR CREMATORY Father Reichen		24d. LOCATION (City, town, or county) (State) Turkwood MO	
DATE REC'D BY LOCAL REG. 5-23-51		REGISTRAR'S SIGNATURE Robert R. Tombs		25. FUNERAL DIRECTOR'S SIGNATURE Shadon J. Gardner		ADDRESS 130 Eldridge	

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

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working under my personal supervision.

Student Embalmer No. *4243*

Student
Student Embalmer

Signed *Theodore J. Yonke*

Licensed Embalmer No. *4243*

P. O. Address *130 Eldridge*

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.