No. 300
10.48

FILED MAY 3 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14826

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3265

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
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): Park Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wellston 4801
d. STREET ADDRESS (If rural, give location): 6417 Wells Av

3. NAME OF DECEASED (Type or Print)
a. (First): Lowell
b. (Middle): B.
c. (Last): Stovall

4. DATE OF DEATH (Month) Apr (Day) 4 (Year) 1952

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jun 25.1902
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country): Brush Prairie Mo 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Robert Stovall
13b. MOTHER'S MAIDEN NAME: Margaret Duker
14. NAME OF HUSBAND OR WIFE: Ruth Stovall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT'S SIGNATURE OR NAME: Ruth Stovall 6417 Wells — ADDRESS

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) Ruptured Gastric ulcer — INTERVAL BETWEEN ONSET AND DEATH: 4 days

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

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

19a. DATE OF OPERATION: 4-4-52
19b. MAJOR FINDINGS OF OPERATION: Generalized peritonitis with ruptured gastric ulcer
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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 31 31 52 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 5401

22. *I hereby certify that I attended the deceased from* 4-3, 1952, *to* 4-4-, 1952, *that I last saw the deceased alive on* 4-4-, 1952, *and that death occurred at* 8P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clyde B Lane M.D.
23b. ADDRESS: 706 Walton
23c. DATE SIGNED: 4-5-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 4-5-52
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Owensville Mo

DATE REC'D BY LOCAL REG.: APR 7 1952
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert H. Hoppe 4700 Washington

(Licensed Embalmer's Statement on Reverse Side)

MAY 23 1952

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 John J. Haines

Licensed Embalmer No. 4608

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.