

FILED FEB 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3320

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0698

1. PLACE OF DEATH a. COUNTY 3		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give township): OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital DOA		e. STREET ADDRESS (If rural, give location) 447 N. Sarah	

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS		b. (Middle) TAYLOR		c. (Last) STONE		4. DATE OF DEATH (Month) (Day) (Year) Jan 21 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Oct 4 1907	
9. AGE (In years last birthday) 46		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Alexander McKee Stone		13b. MOTHER'S MAIDEN NAME Edna Maroes		14. NAME OF HUSBAND OR WIFE Rose Stone	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and date of service) Yes WW # 2		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Edna Nitche		ADDRESS 3540 Wyoming	
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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.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured Esophageal Varix 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		19b. MAJOR FINDINGS OF OPERATION				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) 4621			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 _____, 19____, to _____, 19____; that I last saw the deceased alive on _____, 19____, and that death occurred at 9:55 A.M., from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor Coronel (Degree or title)		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1. 22.54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 23 54		24c. NAME OF CEMETERY OR CREMATORY Calvary	
				24d. LOCATION (City, town, or county) (State) St. Louis Mo	

DATE REC'D BY LOCAL REG. JAN 22 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette	
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WRITE PLAINLY—USING 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, Student Embalmer No. working under my personal supervision. .

Student.....
Signature of Student Embalmer

Signed.....*Thomas R. Fenwick*

Licensed Embalmer No. *379*

P. O. Address *3125 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.