

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25645**

FILED JUL 26 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1557**

|   |                               |  |                                 |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE: <b>Missouri</b> b. COUNTY <b>St. Louis</b> |                                 |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>Koch</b>  |                               | c. LENGTH OF STAY (in this place) <b>4 yrs. 5 mo. 1 da.</b>  |                                 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>   |                               | e. STREET ADDRESS (If rural, give location) <b>2020 South 12th 23<sup>rd</sup></b>   |                                 |
| 3. NAME OF DECEASED<br>a. (First) <b>LESTER</b>   |                               | b. (Middle) <b>IRWIN</b>   |                                 |
| c. (Last) <b>Stoker</b>   |                               | 4. DATE OF DEATH (Month) (Day) (Year) <b>6-24-56</b>   |                                 |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  | 8. DATE OF BIRTH <b>8-15-91</b> |
| 9. AGE (In years last birthday) <b>64</b>   |                               | 10. IF UNDER 1 YEAR: MONTHS _____ DAYS _____   |                                 |
| 11. IF UNDER 24 HRS. Hours _____ Min. _____   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>   |                                 |
| 11. BIRTHPLACE (City and State or Foreign Country) <b>Kennesee</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                 |
| 13a. FATHER'S NAME <b>A. A. Stoker</b>  |                               | 13b. MOTHER'S MAIDEN NAME <b>Josie Hill</b>  |                                 |
| 14. NAME OF HUSBAND OR WIFE <b>Maudie Lyles Stoker</b>  |                               | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                                 |
| 16. SOCIAL SECURITY NO. <b>Unknown</b>  |                               | 17. INFORMANT'S SIGNATURE OR NAME <b>FAY WILLIAMS</b> ADDRESS <b>RECTOR, ARK.</b>  |                                 |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                   |                               | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Emphysema, Bronchopneumonia, pleuritis</b>                  |                                 |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>Postoperative pulmonary reaction for pulmonary tuberculosis</b>                      |                               | INTERVAL BETWEEN ONSET AND DEATH <b>3/6/56</b>   |                                 |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>202x</b>   |                               | 3/6/56   |                                 |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION <b>Pulmonary tuberculosis, emphysema.</b>   |                                 |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <b>9:56 a.m.</b>  |                               | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                              |                                 |
| 21f. HOW DID INJURY OCCUR   |                               |  |                                 |
| 22. I hereby certify that I attended the deceased from <b>3-1-1956</b> to <b>6-24-1956</b> , that I last saw the deceased alive on <b>6-24-1956</b> and that death occurred at <b>9:40 a.m.</b> , from the causes and on the date stated above. |                               |  |                                 |
| 23a. SIGNATURE <b>[Signature]</b>   |                               | 23b. ADDRESS <b>Robert Koch Hospital</b>   |                                 |
| 23c. DATE SIGNED <b>6/24/56</b>   |                               | 23d. (Degree or title)   |                                 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |                               | 24b. DATE <b>6-25-56</b>   |                                 |
| 24c. NAME OF CEMETERY OR CREMATORY <b>Reactor, Ark.</b>   |                               | 24d. LOCATION (City, town, or county) (State)  |                                 |
| DATE REC'D BY LOCAL REG. <b>6-25-56</b>   |                               | REGISTRAR'S SIGNATURE <b>[Signature]</b>   |                                 |
| 25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>   |                               | ADDRESS <b>4700 Washington Blvd.</b>   |                                 |

WRITE PLAINLY—USING UNFADEING 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 *Etienne P. Penel*.....

Licensed Embalmer No. *4283*.....

P. O. Address *St. Louis*.....

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.