

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3108

STATE FILE NUMBER

563

FILED FEB 4 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in lb 37 days		STREET ADDRESS (If outside, give location) 4107 St. Louis Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas P. Stanton				4. DATE OF DEATH Month Day Year January 17th. 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25th. 1874		9. AGE (In years last birthday) 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Mo. State Revenue		11. BIRTHPLACE (City and state or country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas P. Stanton				14. MOTHER'S MAIDEN NAME Anna O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 499-34-9590		17. INFORMANT Marie Stanton		Address 4107 St. Louis Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive arteriosclerotic heart disease</i>							INTERVAL BETWEEN ONSET AND DEATH years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		OK: Joseph M. J. ... 1/27/57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <i>Fracture surgical neck of femur.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Fell in his home</i>					
20c. TIME OF INJURY Hour Month, Day, Year 1 p.m. 12-7-56							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY STATE Mo	
21. I attended the deceased from <i>Dec. 7-56</i> to <i>Jan 17-57</i> and last saw him alive on <i>1-17-57</i> Death occurred at <i>3 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>John J. Maximow M.D.</i>				22b. ADDRESS <i>634 N. Grand</i>		22c. DATE SIGNED <i>1/18/57</i>	
23a. BURIAL, CREATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>Jan. 21st. 1957</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Missouri</i>	
24. FUNERAL DIRECTOR <i>Arthur J. Donnelly</i> ADDRESS <i>3840 Lindell Blvd.</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 18 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i> <i>S.P.</i>	

(Licensed Embolmer's Statement on Reverse Side)

alth, welfare, public service
 300-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Francis William*.....

Licensed Embalmer No. *35*

P. O. Address *3840 E*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.