

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3655**

FILED JAN 17 1958

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **289**

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 289 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis) | | c. LENGTH OF STAY (In this place) 10 days | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital | | | | e. STREET ADDRESS (If rural, give location) #770 4604a Cleveland | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Edna b. (Middle) _____ c. (Last) Stone | | | 4. DATE OF DEATH (Month) (Day) (Year) Jan. 9, 1958 | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | | 8. DATE OF BIRTH Jan 28 1881 | |
| 9. AGE (In years last birthday) 76 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hour _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | | 10b. KIND OF BUSINESS OR INDUSTRY Medical | | 11. BIRTHPLACE (City and State or Foreign Country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Charles Miller | | | 13b. MOTHER'S MAIDEN NAME Martha Freeman | | 14. NAME OF HUSBAND OR WIFE Chas. Stone | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME Charles O. Stone ADDRESS 4604a Cleveland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction | | | | | 6 days. |
| | | ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis Heart Disease | | | | | 6 mo. |
| | | DUE TO (c) Generalized Arteriosclerosis | | | | | 6 mo. |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus | | | | | 6 mo. |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION 420.0 | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) (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 Dec. 30, 1957 , to Jan. 9, 1958 , that I last saw the deceased alive on Jan. 9, 1958 , and that death occurred at 1:05 P. m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) John W. Beckham, M.D. | | | | 23b. ADDRESS 5800 Arsenal | | 23c. DATE SIGNED 1/10/58 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Jan 13 58 | | 24c. NAME OF CEMETERY OR CREMATORY Mount Hope | | 24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo. | |
| DATE REC'D BY LOCAL REG. JAN 10 '58 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette | | | |

(Licensed Embalmer's Statement on Reverse Side)

M. J. B.

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. *3793*

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.