

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042299

STATE FILE NUMBER

10926

FILED DEC 1 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY Enroute to Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis MO		c. CITY OR TOWN St Louis 15	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G Phillips DOA		d. STREET ADDRESS (If outside, give location) 710 4161 St. Louis ave	
3. NAME OF DECEASED (Type or print) Richard Lee Stanford		4. DATE OF DEATH Month 11 Day 11 Year 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Morgan City, Miss
13a. FATHER'S NAME Hosie Stanford		13b. MOTHER'S MAIDEN NAME Elisa Bankhead	14. NAME OF HUSBAND OR WIFE Edna Stanford
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. 486-18-5634	17. INFORMANT Address Edna Stanford 4161 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) Cardio Vascular Disease DUE TO (b) _____ DUE TO (c) 442X			INTERVAL BETWEEN ONSET AND DEATH
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 10:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John E. Doyle (Degree or title) 3		22b. ADDRESS 1300 Ch...	22c. DATE SIGNED 11/13/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-18-58	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) Berkley MO
24. FUNERAL DIRECTOR Hill & Radford ADDRESS 17137 Grand		25. DATE RECD. BY LOCAL REG. NOV 13 58	26. REGISTRAR'S SIGNATURE Paul Smith MO MPB

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Leroy H. Bennett*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.