

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042315
STATE FILE NUMBER
11645
Registrar's No.

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.		d. STREET ADDRESS (If outside, give location) 3643 Arkansas	
3. NAME OF DECEASED (Type or print) First AUGUST Middle J. Last STOLL		4. DATE OF DEATH Month DEC. 1, Day 1958 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1881
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	9b. KIND OF BUSINESS OR INDUSTRY Salesman	9c. BIRTHPLACE (City and state or country) St. Louis, Missouri	9d. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. FATHER'S NAME August B. Stoll		10b. MOTHER'S MAIDEN NAME Mary Peters	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		12. SOCIAL SECURITY NO. 497-18-9087	
13. NAME OF INFORMANT Elizabeth Stoll		14. ADDRESS 3643 Arkansas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct, at lower lobe DUE TO (b) bronchopneumonia at lower lobe DUE TO (c) epidemiol carcinoma of alveolar ridge PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). states post operative cerebral carcinoma of upper alveolar ridge			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.) 144X		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 11/24/58 to 12/1/58 and last saw ^{her} _{him} alive on 12/1/58 Death occurred at 11:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write title) Charles M. G.		22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 12/1/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12-4-58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR Wingbermuehle		25. DATE RECD. BY LOCAL REG. DEC 3 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *E. J. King*
Licensed Embalmer No. *4611*
P. O. Address *St. Louis, Mo.*

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.