URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–042577
STATE FILE NUMBER

FILED VS NOV 20 1959

ENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210409

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Lousi
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Firman-Desloge
Inside Limits: Yes X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes X No ☐
d. STREET ADDRESS (If outside, give location): 4323 Osecola St
Reside on Farm: Yes ☐ No X

3. NAME OF DECEASED (Type or print): First ROBERT Middle POLETTE Last STONE
4. DATE OF DEATH: Month 11 Day 10 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married X Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-26-1938
9. AGE (last birthday): 21Yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): [redacted]Technichan
10b. KIND OF BUSINESS OR INDUSTRY: Reardon Paint Co
11. BIRTHPLACE (City and state or country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY:
13a. FATHER'S NAME: Leroy Stone
13b. MOTHER'S MAIDEN NAME: Norma Polette
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leroy Stone
Address: 4323 Osecola St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: —
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): tetralogy of fallot
DUE TO (c): 754.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I: Cong. failure aneurysm of ascending aorta
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 WORK ☐ NOT WHILE AT WORK ☐
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 Nov 1, 1959 to Nov 10, 1959 and last saw him alive on Nov 9, 1959
Death occurred at 8:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Raymond Slavin (Degree or title) M.D.
22b. ADDRESS Firmin Desloge Hosp.
22c. DATE SIGNED Nov 10, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-13-1959
23c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cemetery
23d. LOCATION (City, town, or county) (State): 1800 Lemay Ferry Rd. Mo

24. FUNERAL DIRECTOR: Ziegenhein Bros
ADDRESS: 6409 Gravois Ave
25. DATE RECD. BY LOCAL REG.: NOV 12 1959
26. REGISTRAR'S SIGNATURE: Hoard Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Van M. Sizem

Signature of Student Embalmer

Licensed Embalmer No. 434

P. O. Address St Louis

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