

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025350
STATE FILE NUMBER

INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1715

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Saint Louis</u> <u>Stellston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>1113 Ogden</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Esther</u> Last <u>Stone</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-1891?</u>	9. AGE (last birthday) <u>66</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (City and state or country) <u>Sedgewickville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Hans, Ely</u>		13b. MOTHER'S MAIDEN NAME <u>Crane, Priscilla</u>		14. NAME OF HUSBAND OR WIFE <u>Harry G. Stone Sr</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Harry G. Stone-9534 Berry Ave.</u> Address <u>1413 OGDEN</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Infarction</u>			
DUE TO (c) <u>Atherosclerosis (cumulative)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ruptured Sanguineous aortic aneurysm</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from May 5, 1960 to 5-30-60 and last saw her/him alive on 5-30-60
Death occurred at 3:40 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Dr. Michael Wittes</u>		22b. ADDRESS <u>6030 Page</u>		22c. DATE SIGNED <u>5-31-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-2-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>	
24. FUNERAL DIRECTOR <u>SHEPARD FUNERAL HOME</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-1-60</u>	26. REGISTRAR'S SIGNATURE <u>John M. [Signature]</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

