

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5343** STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. XXXXX City of St. Louis				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		Length of stay in 1b 28 days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Frisco Employes' Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3723 Connecticut		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Harvey Rose Stone				4. DATE OF DEATH Month Day Year June 7, 1961					
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 1-28-85	9. AGE (last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Bloomfield, Ky.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James W. Stone			13b. MOTHER'S MAIDEN NAME Laurie Rose		14. NAME OF HUSBAND OR WIFE Belle Collins 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. unknown		17. INFORMANT Address Wife Same-3723 Connecticut				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Pulmonary Embolus							Acute		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Heart Failure with Pulmonary Edema							Acute		
DUE TO (c) 541.0									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Partial Gastrectomy for Duodenal Ulcer 6-5-61					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. 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 May 10, 1961 to June 6, 1961 and last saw ^{her} him alive on June 6, 1961 Death occurred at 12:25 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>James W. Hales M.D.</i>				22b. ADDRESS 4960 Laclede				22c. DATE SIGNED 6-7-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 10, 1961	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) St. Louis County, Missouri (State)				
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave.				25. DATE RECD. BY LOCAL REG. JUN 8 1961		26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

MEDICAL CERTIFICATION

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Flaura M. Billo

Licensed Embalmer No. 4375

P. O. Address St. Louis 13, 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.