

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

**791
1003**

File No. **39162**
Registered No. **11336**

1. PLACE OF DEATH

County Registration District No.
Township Primary Registration District No.
City St Louis (No. 4508, Chouteau Ave) St. Ward)

2. FULL NAME Alice Stamps

(a) Residence, No. 4508 Chouteau St., 18 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF late Martin Stamps

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 10, 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 6 30

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) St Louis (STATE OR COUNTRY) Mo

MOTHER FATHER 13. NAME Donnis Godfrey

14. BIRTHPLACE (CITY OR TOWN) Ireland (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Margaret O'Donno

16. BIRTHPLACE (CITY OR TOWN) Ireland (STATE OR COUNTRY)

17. INFORMANT Mrs Alice A'Hearn (ADDRESS) 4508 Chouteau Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Cadaver DATE 11-12-31

19. UNDERTAKER Kriegshauser (ADDRESS) 4104 Montmorency Ave

20. FILED 12-31-31 19 Max E. Stamps Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-9-31

22. I HEREBY CERTIFY That I attended deceased from May 6 1931 to Nov 9 1931. I last saw him alive on Nov 5 1931. Death is said to have occurred on the date stated above, at 9:30 p.m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocardite
93C
Other contributory causes of importance: 93C

Name of operation None Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury 93C

24. Was disease or injury in which was related to occupation of deceased? No
If so, specify 93C
(Signed) Max E. Stamps, M. D.
(Address) 1537 Grand Ave

No. of item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No. 11336
City..... St..... Ward.....

2. FULL NAME

Alice Stamps

(a) Residence. No..... St..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 10th 1885*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>79</i>	<i>6</i>	<i>30</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT *Isabel Cheam*
(Address) *4508 Chautau*

15.

FILED *DEC - 3, 19* *May E Starkloff*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov - 9th 1930*

17. I HEREBY CERTIFY, That I attended deceased from
that I last saw h..... since on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. DEATH in place, terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-39162

STICU
MAY 1962

STICU
MAY 1962

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