

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every 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.

Registration District No. **791**  
**1003** Primary Registration District No. Registrar's No. **7185**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St Louis Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4515 Beacon  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Albert L Stephenson **315**  
3. (b) If veteran, \_\_\_\_\_ name war \_\_\_\_\_  
3. (c) Social Security No. 493-09-20

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife Myrtle Stephenson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 12 18 1875  
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St Louis Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business Unemployed

FATHER { 12. Name Albert Stephenson  
13. Birthplace St Louis Mo  
(City, town, or county) (State or foreign country)  
MOTHER { 14. Maiden name Sarah Lockwood  
15. Birthplace St Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wm Albee Young  
(b) Address 4515 Beacon

17. (a) Burial (b) Date thereof 8-19-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Proctor and Co  
(b) Address 3710 N Grand Blv

19. AUG 18 1939 (b) J. B. Proctor  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis **7**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4515 Beacon Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 16  
year 1939 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from 2-27-37  
\_\_\_\_\_, 19\_\_\_\_, to 8-16, 1939;  
that I last saw him alive on 8-16, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death Lympho-sarcoma of mediastinum  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy No  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature H. Klein (At or other) \_\_\_\_\_  
Address 5074 N Union Date signed 8-19-39

Dr. Harry Klein  
5074  
- 6-8 -  
11  
1020

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Robert L. Brinkman*

Licensed Embalmer No. *3553*

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**