. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 3 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

21496

State File No.

Registrar's No. 1643

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence; 207 Central Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Clayton,
(If outside city or town limits, write "RURAL")
(d) Street No. 207 No. Central Ave.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME KATHERINE MONTAGUE STINDE.

3. (b) If veteran, name war none.

3. (c) Social Security No. none.

4. Sex Female.

5. Color or race White.

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Eugene B. Stinde.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 21, 1882. (Month) (Day) (Year)

8. AGE: — Years 62. Months 6. Days 7. If less than one day hr. min.

9. Birthplace Bristol, (City, town, or county) Virginia. (State or foreign country)

10. Usual occupation At Home.

11. Industry or business

FATHER
12. Name James Clark Stone.
13. Birthplace (City, town, or county) Canada. (State or foreign country)

MOTHER
14. Maiden name Louise Montague.
15. Birthplace Bristol, (City, town, or county) Virginia. (State or foreign country)

16. (a) Informant Mrs Wm Doyle.
(b) Address 207 N. Central Ave.,

17. (a) Burial. (Burial, cremation, or removal) (b) Date thereof 6/30/45. (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.,

18. (a) Signature of funeral director C.R.Lupton & Sons.
(b) Address 7233 Delmar Blvd.

19. (a) 6-28-45 (Date received local registrar) (b) E. G. McGann (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28th year 1945 hour 8:15 minute A. M.

21. I hereby certify that I attended the deceased from March 26, 1938, to June 28, 1945, that I last saw her alive on June 27, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage — Duration 1941

Due to vascular hypertension — 1938

Due to 830

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Samuel B. Grant (M. D. or other) M.D.
Address 1141 N. Taylor Ave. Date signed 6/28/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Sam B. Grant.
114 No. Taylor.
Je- 8600
Hrs. 1-4 P.M.

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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City, 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 this body is not embalmed, fact should be so stated above.