

V. S. No. 2  
00M-5-43  
Rev. 5-17-39  
I X36871

32423

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 2 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9184

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

1. PLACE OF DEATH:

(a) County..... St. Louis

(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4607 Shenandoah /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 35 years (Specify whether years, months or days)

In this community..... 35 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000

(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL") 1717

(d) Street No. 4607 Shenandoah  
(If rural, give location) 9

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country.....

3. (a) PRINT FULL NAME Charles Ralfert Stone

3. (b) If veteran, name war..... no

3. (c) Social Security No. 488-05-3498

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23  
year 1945 hour 4:15 minute A. M.

21. I hereby certify that I attended the deceased from August 18, 1943, to Oct 23, 1945, that I last saw him alive on Oct 22, 1945, and that death occurred on the date and hour stated above.

4. Sex male 0 5. Color or race white

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

6. (b) Name of husband or wife..... Rose Stone

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

7. Birth date of deceased..... June 17, 1872  
(Month) (Day) (Year)

Immediate cause of death  
Coronary Arteriosclerosis

Due to.....

Due to.....

Other conditions Myocarditis Chronic  
(Include pregnancy within 9 months of death)  
Arterio-Sclerosis

Major findings:  
Of operations.....

Of autopsy..... none

8. AGE:

Years	Months	Days	If less than one day
73	4	6	..... hr. .... min.

9. Birthplace Little Rock Ark.  
(City, town, or county) (State or foreign country)

10. Usual occupation Store manager

11. Industry or business retail clothing

12. Name Jacob Stone

13. Birthplace Poland 4  
(City, town, or county) (State or foreign country)

14. Maiden name Rachel (unk)  
(City, town, or county) (State or foreign country)

15. Birthplace Poland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph S. Stone

(b) Address 7049 Pershing

17. (a) burial (b) Date thereof 10-24-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Mt. Sinai

18. (a) Signature of funeral director Berger Memorial

(b) Address 4715 McPherson Avenue

19. (a) OCT 24 1945 J. F. Bredek (Date received local registrar) (Registrar's signature)

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature J. F. Bredek (M. D. or other) 710  
Address 812 Olive Street Date signed 10/24/45

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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.....



Licensed Embalmer No. 1597

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, fact should be so stated above.**