No. 2
I—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18945

State File No. 4694

FILED JUN 6 1946

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

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: Barnes Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis, 96-0

(c) City or town Jennings, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 8324 College Ave. NRO 1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Fred Stokes

3. (b) If veteran, name war

3. (c) Social Security No. 489-09-5275

4. Sex Male

5. Color or race Wht.

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

6. (b) Name of husband or wife Josephine

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased: March (Month) 9th (Day) 1891 (Year)

8. AGE: Years 55 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Springfield (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Electrician

11. Industry or business

FATHER
12. Name John Stokes Sr 4
13. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Anna Meyers
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Josephine Stokes
(b) Address 8324 College Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/25/46 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Mark Timmons
(b) Address 6400 W. Florissant

19. (a) MAY 25 1946 (Date received local registrar) (b) J. J. Brudeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22 year 1946 hour 7 0 minute 10 P M.

21. I hereby certify that I attended the deceased from May 7, 1946, to May 22, 1946; that I last saw him alive on May 22, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ? malignant lymphoma - with cardiac failure	18 mos
Due to bronchopneumonia & pleural effusion	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy ? malignant lymphoma gross examination

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 F R Bradley (M. D. or other)

Address Barnes Hospital Date signed 5/22/46

(Licensed Embalmer's Statement on Reverse Side)

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 Mark Emerson

Licensed Embalmer No. 4174

P. O. Address 6100 W. Florissant

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.

S. No. 2B
5M—3-45
1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18945

Registration District No. 318   Primary Registration District No. 1003   Registrar's No. 4694

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

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

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

3. (a) PRINT FULL NAME Fred Stoker
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 9 189[illegible] (Month) (Day) (Year)
8. AGE: Years 55 Months 6 Days 13 If less than one day hr. min.
9. Birthplace (City, town, or county) MO (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May 22 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from 19 , to 19 ;
that I last saw h alive on 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Cancer-lymphoma-primary site unknown   Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations 552
Of autopsy Enlarged cervical, axillary, retroperitoneal, hepatic lymph glands

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

17823

18945