S. No. 2
I—8-43
5-17-39
I X37623

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35642

FILED NOV 7 1946

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9072

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: Christian Hosp. O
(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 Mo (b) County 000
(c) City or town St Louis 717
(If outside city or town limits, write "RURAL")
(d) Street No. 4917 Leahy 9
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALBERT LEO STOLL
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Lillian V. Stoll
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Oct (Month) 17 (Day) 1889 (Year)
8. AGE: Years 57 Months 0 Days 4 If less than one day hr. min.
9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Foreman
11. Industry or business
FATHER 12. Name Albert Stoll
13. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace 9 (City, town, or county) (State or foreign country)
16. (a) Informant Lillian V. Stoll
(b) Address 4917 Leahy Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 24 46 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director Hannigan & Sheehan
(b) Address 4415 Washington Bl.
19. (a) OCT 23 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21 year 1946 hour 10 minute 10 P.M.
21. I hereby certify that I attended the deceased from Oct 18 1946 to Oct 21 1946 that I last saw him alive on Oct. 21 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Hypertension
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy None

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 0
23. Signature J. Roy Condlon (M. D.)
Address 612 Ph. Bldg Date signed 10/23/46

(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.....

Licensed Embalmer No.....

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.