

No. 2
2-45
17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **11578**
Registrar's No. **2555**

Registration District No. **318** Primary Registration District No. _____

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:
5017 Ruskin Ave
(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 **Walter S. Stone**
3. (b) If veteran, name war _____
3. (c) Social Security No. **489-07-6413**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Frieda Stone**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Sep 2 d, 1876**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 ----- **6** **28** hr. min.

9. Birthplace **Dayton Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **Shoemaker**

11. Industry or business _____
12. Name **Walter Stone** **9**
13. Birthplace **Not Known** **1**
(City, town, or county) (State or foreign country)
14. Maiden name **Not Known**
15. Birthplace **Not Known** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frieda Stone**
(b) Address **5017 Ruskin Ave 1947**
17. (a) **Burial** (b) Date thereof **March 13 Th**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Hiram Cemetery**

18. (a) Signature of funeral director **Edward Kael**
(b) Address **3516 N 14 Th Str**
MAR 11 1947
19. (a) _____ (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **oas**
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL") **7 17**
(d) Street No. **5017 Ruskin Ave**
(If rural, give location) **9**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar.** day **10th**
year **1947** hour **6:45** minute **P** M.
21. I hereby certify that I attended the deceased from **Mar 10**
20th, 19 **47**, **Mar 10**, 19 **47**
that I last saw him alive on **3-10-** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Failure Organic**
arteriosclerosis
Due to _____

Due to _____
Other conditions **Hemiplegia**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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) _____ (Specify means of injury) **2**
23. Signature **Scott** (D. O. M. H. E. I.)
Address **4356 Hawthorn** Date signed **3-11-47**

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

MOTHER FATHER

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

Rev. E Campbell

Licensed Embalmer No.

3881

P. O. Address

W. Davis Wm

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.