

No. 300
10. 46

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10639**
Registrar's No. **2270**

FILED MAR 29 1952

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 3 yrs.		d. STREET ADDRESS (If rural, give location) 15 4437 Louisiana	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4437 Louisiana			

3. NAME OF DECEASED (Type or Print) a. (First) Ira		b. (Middle) E		c. (Last) Stone		4. DATE OF DEATH (Month) (Day) (Year) Mar. 9, 1952	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 13, 1879	
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months Days		IF UNDER 1 HR. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S.		11. BIRTHPLACE (State or foreign country) Campbell Hill Illinois		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Irby C Stone		13b. MOTHER'S MAIDEN NAME Sarah Wayland		14. NAME OF HUSBAND OR WIFE Myrtle D Stone	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ralph J Stone		ADDRESS 5012 Welshusen	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF LEFT LUNG.				INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 162X	

22. I hereby certify that I attended the deceased from **Dec 29, 1950**, to **Mar. 9, 1952**, that I last saw the deceased alive on **Mar 8, 1952**, and that death occurred at **6:00 AM** from the causes and on the date stated above.

23a. SIGNATURE Goman John M D (Degree or title)		23b. ADDRESS 1500 Virginia Ave		23c. DATE SIGNED 3-7-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/11/52		24c. NAME OF CEMETERY OR CREMATORY Central Baptist Ch. Cem. Willisville, Ill.		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REG. MAR 11 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE J.L. Ziegenhein & Sons		ADDRESS 7027 Gravois	
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7027 Gravois

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.