

FILED JUN 27 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22686  
Registrar's No. 5270

318

1003

|  |  |  |  |   |   |   |                                |  |                      |
|--|--|--|--|---|---|---|--------------------------------|--|----------------------|
| BIRTH NO. _____  |  | REG. DIST. NO. 318   |  | PRIMARY REG. DIST. NO. 1003   |   | State File No. 22686                                |                                | Registrar's No. 5270   |                      |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY _____ |   |   |                                |  |                      |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.  |  | c. LENGTH OF STAY (In this place) 17 Hrs.  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis                                      |   | 2079  |                                |  |                      |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital   |  |  |  | d. STREET ADDRESS (If rural, give location) 7 4518 Geraldine Ave. 0   |   |   |                                |  |                      |
| 3. NAME OF DECEASED (Type or Print) a. (First) Elsie   |  | b. (Middle) M.   |  | c. (Last) Stange  |   | 4. DATE OF DEATH (Month) (Day) (Year) June 8, 1952. |                                |  |                      |
| 5. SEX Female  | 6. COLOR OR RACE White   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married  | 8. DATE OF BIRTH June 16, 1899                               |   | 9. AGE (In years last birthday) 52  | IF UNDER 1 YEAR Months                              | IF UNDER 1 YEAR Days           | IF UNDER 1 YEAR Hours  | IF UNDER 1 YEAR Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY Home   |  | 11. BIRTHPLACE (State or foreign country) Madison, So. Dakota   |   | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                 |                                |  |                      |
| 13a. FATHER'S NAME ? Smith   |  |  | 13b. MOTHER'S MAIDEN NAME Minnie Burke                       |   |   | 14. NAME OF HUSBAND OR WIFE Mr. Raymond Stange      |                                |  |                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No  |  | 16. SOCIAL SECURITY NO. None   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Raymond Stange, 4518 Geraldine Ave.   |   |   |                                |  |                      |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   | MEDICAL CERTIFICATION  |  |  |   |   |   |                                | INTERVAL BETWEEN ONSET AND DEATH   |                      |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arterio-sclerotic stroke, Right</i>  |  |  |   |   |   |                                | 10 hours   |                      |
|  | ANTECEDENT CAUSES  |  |  |   |   |   |                                |  |                      |
|  | *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  |  |   |   |   |                                |  |                      |
|  | Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.   |  |  |   |   |   |                                |  |                      |
|  | DUE TO (b) <i>Cerebral Hemorrhage</i>  |  |  |   |   |   |                                |  |                      |
|  | DUE TO (c) <i>Hypertension</i>   |  |  |   |   |   |                                |  |                      |
|  | 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 checked="" type="checkbox"/> |                      |
| 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)   |   | 331X  |                                |  |                      |
| 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?  |   |   |                                |  |                      |
| 22. I hereby certify that I attended the deceased from <i>6-8-1952</i> to <i>6-8-1952</i> , that I last saw the deceased alive on <i>6-8-1952</i> , and that death occurred at <i>11:00P</i> m., from the causes and on the date stated above. |  |  |  |   |   |   |                                |  |                      |
| 23a. SIGNATURE (Degree or title) <i>W. W. Garrison M.D.</i>  |  |  |  | 23b. ADDRESS <i>3506 N. Grand</i>   |   |   | 23c. DATE SIGNED <i>6-9-52</i> |  |                      |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>   |  | 24b. DATE <i>6-12-1952.</i>  | 24c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i> |   | 24d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>                    |   |                                |  |                      |
| DATE REC'D BY LOCAL REG. <i>JUN 9 1952</i>   |  | REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>   |  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Math Hermann &amp; Son Inc. 2161 E. Fair Ave.</i> |   |                                |  |                      |

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

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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 *Welford G. Burnley* \_\_\_\_\_

Licensed Embalmer No. *42070* \_\_\_\_\_

P. O. Address *St. Louis, Mo.* \_\_\_\_\_

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.