

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JUN 4 1953

State File No. **19940**
5200

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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 township) OR TOWN ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		129 5351 Delmar	

3. NAME OF DECEASED (Type or Print) MAYME STONE			4. DATE OF DEATH (Month) (Day) (Year) MAY 23 1953		
a. (First)	b. (Middle)	c. (Last)	8. DATE OF BIRTH	9. AGE (In years less birthday)	IF UNDER 1 YEAR
F	W	STONE	JULY 13 1870	82	Months Days Hours Mins.
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
				Widowed	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
Ret Housewife					
11. BIRTHPLACE (City and State or Foreign Country)				12. CITIZEN OF WHAT COUNTRY?	
Chester IL				USA	

13a. FATHER'S NAME Jacob Keller		13b. MOTHER'S MAIDEN NAME Hattie Williamson		14. NAME OF HUSBAND OR WIFE Harry M Stone	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mr. Robertson Masonic Home of Mo	
ADDRESS					

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				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis				years	
		ANTECEDENT CAUSES Morbid 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 checked="" 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4500	
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22. I hereby certify that I attended the deceased from 4-21-53, 19____, to 5-23-53, 19____, that I last saw the deceased alive on 5-23-53, 19____, and that death occurred at 9:40Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert Healey M.D.		23b. ADDRESS 1515 LAFAYETTE AVE.		23c. DATE SIGNED 5-24-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5-25-53		24c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cem Pleasant Hill Mo		24d. LOCATION (City, town, or county) (State)	
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 25 1953		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE W. Alexander Sons		ADDRESS 6175 Delmar	
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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

Jose E. McCulloch

Licensed Embalmer No. *2460*

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

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.