

pt. Health,
, & Welfare
S. Public
alth Service

FILED DEC 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1003

42666
STATE FILE NUMBER
11388
Registrar's No.

Registration District No. 318 Primary Registration District No.

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St Louis mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>25 ST. LOUIS CITY HOSP.</i>		Length of stay in lb <i>#1.</i>	d. STREET ADDRESS (If outside, give location) <i>715 4440 Tyler av</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>HENRY-RICHARD STOVALL</i>			4. DATE OF DEATH Month Day Year <i>NOV. 25, 1957</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug: 5 - 1879</i>	9. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>Nashville, Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Wm Brown</i>		13b. MOTHER'S MAIDEN NAME <i>Wm Brown</i>		14. NAME OF HUSBAND OR WIFE <i>Gertrude Stovall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>486-16-1689</i>	17. INFORMANT Address <i>William Stovall 4458 McMillan Ave.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage suspected</i>					INTERVAL BETWEEN ONSET AND DEATH <i>13 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>generalized arteriosclerosis.</i>					
DUE TO (c) <i>331x</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>11/8/57</i> to <i>11/25/57</i> and last saw her/him alive on <i>11/25/57</i> Death occurred at <i>8:45 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Robert F. Owen</i> (Degree or title)			22b. ADDRESS <i>1515 LAFAYETTE AVE.</i>		22c. DATE SIGNED <i>11/26/57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>11-27-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baldale Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Lemay, Missouri</i>
24. FUNERAL DIRECTOR <i>Thomas Jackson</i> ADDRESS <i>2726 Dribson</i>			25. DATE RECD. BY LOCAL REG. <i>NOV 27 57</i>	26. REGISTRAR'S SIGNATURE <i>J Carl Smith mo</i> <i>G.P.</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(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, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed NOT- EMBALMER

Thomas Jackson 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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