

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46360

STATE FILE NUMBER

FILED DEC 20 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No. 11975

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5445 N Kingshighway</b>		Length of stay in hospital <b>2 yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>5445 N. Kingshighway</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>FRED J. STOCKMAN</b>			4. DATE OF DEATH Month Day Year <b>Dec. 12, 1957</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1893</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days <b>10 12</b>	IF UNDER 24 HRS. Hours Min. <b>10 12</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>tool &amp; die maker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Acme Tool Co.</b>	11. BIRTHPLACE (City and state or country) <b>Belleville, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Fred J. Stockman</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Feder</b>	14. NAME OF HUSBAND OR WIFE <b>Cecilia Stockman</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>333-03-5267</b>	17. INFORMANT <b>Cecilia Stockman</b>	Address <b>5445 N. Kingshigh-</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral arteriosclerosis</b>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331 +</b>		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from <b>7-19-55</b> to <b>12-12-57</b> and last saw <sup>him</sup> alive on <b>12-2-57</b> Death occurred at <b>8:30 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Charles J. Florissant</b> (Degree or title)	22b. ADDRESS <b>6000 W. Florissant</b>	22c. DATE SIGNED <b>12-13-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Dec 16 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Bromschwig and Son/ W Florissant</b>	ADDRESS <b>4746</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 13 57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>
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(Licensed Embalmer's Statement on Reverse Side)

7196

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAR 4 1959

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 Thomas A. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis

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.