

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038265  
STATE FILE NUMBER

NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9984

|  |                           |   |  |   |   |
|--|---------------------------|---|--|---|---|
| 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, give TOWNSHIP only)<br>OR TOWN St. Louis   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN St. Louis  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| 38 c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION DOA City Hosp  |                           | Length of stay in 1b  | d. STREET ADDRESS 4604a Cleveland  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Charles O Stone  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Oct 19 1958  |   |   |
| 5. SEX<br>Male <input checked="" type="checkbox"/>   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Nov 1 1883   |   | 9. AGE (In years last birthday)<br>74   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Salesman  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Mfg. Agent   | 11. BIRTHPLACE (City and state or country)<br>Iowa /   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |
| 13a. FATHER'S NAME<br>Otto Seiter  |                           | 13b. MOTHER'S MAIDEN NAME<br>Katherine Mullen   |  | 14. NAME OF HUSBAND OR WIFE<br>Edna Miller                |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Mrs A.O. Woerner 5 Lindworth Dr          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____<br>DUE TO (c) <u>420.1</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |                           |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 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<br>Hour Month, Day, Year<br>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                 |   |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at <u>1200 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |   |   |
| 22a. SIGNATURE<br><u>James M Kelly</u> (Degree or title) <u>Deputy</u>   |                           | 22b. ADDRESS<br><u>1300 Clark</u>   |  | 22c. DATE SIGNED<br><u>10.20.58</u>                       |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |                           | 23b. DATE<br>Oct 21 58  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Calvary             |   |
| 23d. LOCATION (City, town, or county) (State)<br>St. Louis Mo  |                           |   |  |   |   |
| 24. FUNERAL DIRECTOR<br>E. J. SCHNUR • 3125 LAFAYETTE  |                           | 25. DATE RECD. BY LOCAL REG.<br>OCT 20 58   |  | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith MD</u><br>mgo. |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Jon B. Vollmer* .....

Licensed Embalmer No. *4814* .....

P. O. Address *3125 Lejeune* .....

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.