

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011431

STATE FILE NUMBER
2-2574

FILED APR 6 1959 Registration District No. Primary Registration District No. Registrar's No.

300
1-57
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35
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN Bridgeton 4070	
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 3730 Harmony Lane	

3. NAME OF DECEASED (Type or print) First Middle Last WALTER H. STONE			4. DATE OF DEATH Month Day Year MARCH 12, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6-1903	9. AGE (In years last birthday) 55	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor	10b. KIND OF BUSINESS OR INDUSTRY Cement	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Solomon Stone	13b. MOTHER'S MAIDEN NAME Sadie Abel	14. NAME OF HUSBAND OR WIFE Lelia M. Stone
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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) No	16. SOCIAL SECURITY NO. 497-10-3630	17. INFORMANT Address Lelia M. Stone 3730 Harmony Lane
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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) Epidermoid Carcinoma of Brain		INTERVAL BETWEEN ONSET AND DEATH 6 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 10/30/58 to 3/12/59 and last saw him alive on 3/12/59
Death occurred at 3:25 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. C. Miller, M.D.</i> (Degree or title) D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/13/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-14-1959	23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery	23d. LOCATION (City, town, or county) (State) St. Ann, Missouri
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24. FUNERAL DIRECTOR Collier Mortuary, St. Ann, Mo.	25. DATE RECD. BY LOCAL REG. MAR 13 '59	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *St Ann's 7*

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.