RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=60-037085

FILED VS SEP 1 9 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2675 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY: ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MEHLVILLE — Length of stay in 1b: 6 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: FULLER NUR. HOME — Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: ST LOUIS
c. CITY OR TOWN: U. CITY — Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 7548 STANFORD — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: ROBERTA Middle: — Last: STONE

4. DATE OF DEATH: Month: SEPT Day: 8 Year: 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐ BABY
8. DATE OF BIRTH: JULY-21-60
9. AGE (last birthday): 0 — IF UNDER 1 YEAR: Months 1 Days 18 — IF UNDER 24 HR: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIL
10b. KIND OF BUSINESS OR INDUSTRY: NIL
11. BIRTHPLACE (City and state or country): ST LOUIS MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: GREGORY P. STONE
13b. MOTHER'S MAIDEN NAME: MARGARET CUTHBERTSON
14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: GREGORY P. STONE — Address: 7548 STANFORD U. CITY MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Congenital malformation of heart, type undetermined
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 18 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Congenital absence of both feet, left hand, right hand, and partial right shoulder

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☑ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Sept. 4, 1960 to and last saw her/him alive on Sept. 4, 1960
Death occurred at 4 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Chas Krueb M.D. (Degree or title)
22b. ADDRESS: 8070 Delmar St L Mo
22c. DATE SIGNED: 9/10/60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: SEPT-12-60
23c. NAME OF CEMETERY OR CREMATORY: NEW ST JOHNS CEM
23d. LOCATION (City, town, or county) (State): MEHLVILLE MO

24. FUNERAL DIRECTOR ADDRESS: FEY FUNERAL HOME MEHLVILLE MO
25. DATE RECD. BY LOCAL REG.: 9-10-60
26. REGISTRAR'S SIGNATURE: John B. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

No EMBALMING.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to c 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.