

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9853

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Physicians should state the name of disease or injury. Do not use this space.

APR 24 1929

1. PLACE OF DEATH

County Carroll
Towship
City Carrollton (No.)

Registration District No. 135
Primary Registration District No. 3030

File No.
Registered No. 27
St. Ward

2. FULL NAME Laurance Stemple

(a) Residence No. Benton St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Christine Fox Stemple

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-26-1831

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
97 6 15

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Gun-smith
(b) General nature of industry, business, or establishment in which employed (or employer) 1800
(c) Name of employer 1910
1000

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Andrew Stemple

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Edie Sigmer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mae Stemple
(Address) Carrollton Mo

15. FILED 3-15 1929 Mrs. E. E. Farnham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 2 1929 to March 14 1929 that I last saw him alive on Feb 6 1929 and that death occurred, on the date stated above, at about 3 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
accidental
CONTRIBUTORY Machine Night gun
(SECONDARY)
Nov 29 1929 (duration) yrs. mos. da.
tried to get up & walk & fell to floor

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? HTA
(Signed) R. T. Hark M. D.
March 14 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Hill Cem DATE OF BURIAL 3-16 1929

20. UNDERTAKER Stanley ADDRESS Carrollton

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CERTIFICATE OF DEATH**

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Carrroll Registration District No. 133- File No.
 Townsh. Primary Registration District No. 3031 Registered No. 27
 City Carralton (No.) St. Ward)

2. FULL NAME

Lawrence Stemple
 (a) Residence. No. St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 19. Mrs. E. E. Farabee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14-1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h. alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

fractured right femur
 tried to get up & walk
 & fell to the floor
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

1985
 WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) , M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

PHYSICIANS OCCUPATION is ve: LETE AS PRESCRIBED BY
 applied. AGE should be state properly classified. Exact state OR CERTIFICATES UNTIL THEY ARE C
 any item of information F DEATH in plain terms, REGISTRARS SHALL NOT RECEIVE A

SUPPLEMENTARY

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