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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **24929**

Registration District No. **11 04 218**

Primary Registration District No. **3015**

Registrar's No. **94**

1. PLACE OF DEATH:

(a) County **Cooper**
(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Days**
(Specify whether
In this community **Life 46 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Howard**
(c) City or town **Franklin,**
(If outside city or town limits, write "RURAL")
(d) Street No. **Gen. Delivery**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles G. Stangl**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **702-12-7071**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Stella Stangl** 6. (c) Age of husband or wife if alive **41** years
7. Birth date of deceased **July 11, 1895**
(Month) (Day) (Year)

8. AGE: Years **46** Months **0** Days **13** If less than one day
hr. min.

9. Birthplace **Howard County, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Fireman**

11. Industry or business **Rail-Road**

MOTHER, FATHER { 12. Name **Jacob Stangl**
13. Birthplace **Unknown** 9
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Frank**
15. Birthplace **Unknown** 1
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Stella Stangl**
(b) Address **Franklin, Missouri**

17. (a) **Burial** (b) Date thereof **July 27/41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Walnut Grove Cem.**

18. (a) Signature of funeral director **L. J. Meister**
(b) Address **Boonville, Missouri**

19. (a) **8-1-41** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **24**
year **1941** hour **1.00** minute **P.** M.

21. I hereby certify that I attended the deceased from **July 20** 19**41**, to **July 24** 19**41**
that I last saw him alive on **July 24** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **apoplexy cerebral haemorrhage**
Duration **4 days**

Due to **[Signature]**
Due to **[Signature]**

Other conditions **Broncho-pneumonia 2 days**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **aspiration broncho pneumonia; cerebral pneumonia**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **[Signature]**
Address **New Franklin Mo** Date signed **7-25-41**

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 7 1941

OCT 6 1941

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

C. R. Frelund

Licensed Embalmer No. *1399*

P. O. Address *Highway 100*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. 24929
Registrar's No. 94

Registration District No. 218

Primary Registration District No. 3015

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community Life 46 years, 4 da.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howard
(c) City or town Franklin
(If outside city or town limits, write "RURAL")
(d) Street No. Gen Delvery
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles E Stang

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single m widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year) _____

8. AGE: Years Months Days If less than one day _____ min.

9. Birthplace (City, town, or county) (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-19-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 24 Year 1941 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? (City or town) (County) (State) _____

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-24929