

BUREAU OF THE CENSUS  
FILED FEB 13 1943

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Franklin  
(b) City or town Sullivan  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 3 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Louise Katy Stelling  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 9  
year 1943 hour 6 minute 0 M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Herman Stelling 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 16, 1859  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1, 1942 to 1-9-1943  
that I last saw her alive on 1-9-1943  
and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 1 Days 24 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Cerebral hemorrhage  
Duration 11 Days

9. Birthplace Beaufort Mo. 0  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation House wife

Other conditions arteriosclerosis Hypertension  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

PHYSICIAN  
Major findings: None  
Of operations \_\_\_\_\_  
Of autopsy None  
Underline the cause to which death should be charged statistically.

MOTHER FATHER  
12. Name Carrier Blumeyer  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Blumeyer  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant Bern Stelling

(b) Address 2837 Hewitt St. Fair

17. (a) burial (b) Date thereof Jan 12, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation odd fellow cemetery

18. (a) Signature of funeral director Samuel J. Lopez  
(b) Address St. Clair Mo

19. (a) 1-12-43 (b) Albert Wilhaus  
(Date received local registrar) (Registrar's signature)

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)  
Means of injury \_\_\_\_\_  
23. Signature Albert Wilhaus (M. D. or other) \_\_\_\_\_  
Address Sullivan Mo Date signed 1-11-43

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

36  
4  
0

**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 *Joe L. Wheeler*

Licensed Embalmer No. *3008*

P. O. Address *Pacific, Mo*

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