

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

38632

State File No. ....

Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Lin

(b) City or town Marceline  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community 5 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lin 58

(c) City or town Marceline 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 213 Curtis  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 1

3. (a) PRINT FULL NAME BARBRA STAZIA HELDT

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred Heldt 6. (c) Age of husband or wife if alive 78 years

7. Birth date of deceased Dec 7 1867  
(Month) (Day) (Year)

| 8. AGE: | Years     | Months    | Days      | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
|         | <u>75</u> | <u>11</u> | <u>20</u> | .....hr. ....min.    |

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

10. Usual occupation House wife

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

12. Name Joseph Benedict

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

14. Maiden name Anna Bartus

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

16. (a) Informant Tillie Benedict

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof 11-27-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cash

18. (a) Signature of funeral director James McLaughlin

(b) Address Marceline Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24  
year 1943 hour 11 minute 55 P.M.

21. I hereby certify that I attended the deceased from Nov. 20, 1943, to Nov. 24, 1943  
that I last saw her alive on Nov. 24, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of uterus

Duration 1 year

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

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

Other conditions HST  
(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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (b) Means of injury car

23. Signature John W. Allen (M. D. or Other) D.W.

Address Marceline Mo Date signed 11/24/43

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

MOTHER FATHER

**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 *Mrs Blanche M Taigle*  
Licensed Embalmer No. *19019*  
P. O. Address *Marceline m*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 9

Registration District No. 385 Primary Registration District No. 3039

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Barbara Stojia Seldt

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

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

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

7. Birth date of deceased See 4/18/1888  
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 1 If less than one day, min.

9. Birthplace Chester, Mo.  
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 11-26-43 (b) P. J. Patuck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 4 Year 1943 Hour 10 minute 15 M.

21. I hereby certify that I attended the deceased from 10/18/43 to 11/4/43, 1943; that I last saw him alive on 11/4/43, 1943; 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)

(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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

38632