

FILED NOV 18 1943

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution; McCormick Hospital
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 4 weeks (Specify whether)
In this community 71 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. H 16 North Moulton (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CHARLES FREDRICK STAIGER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married Divorced Widowed
6. (b) Name of husband or wife Louise Staiger alive _____ years
7. Birth date of deceased April - 19 - 1853
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 6 10 hr. min.

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

10. Usual occupation Shoe Cobbler (Retired)

11. Industry or business _____

MOTHER FATHER { 12. Name Paul Staiger 4

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

14. Maiden name Unknown

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

16. (a) Informant Miss Lattie Staiger

(b) Address H 16 N. Moulton Moberly MO

17. (a) Burial (b) Date thereof Oct - 31 - 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo.

18. (a) Signature of funeral director Snow Funeral Home

(b) Address Moberly Mo

19. (a) 10-31-43 (b) John Haver
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29th
year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 10-21, 1943, to 10-29, 1943

that I last saw him alive on 10-29, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia
Fracture right femur
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓ 127
(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) (c) Means of injury _____

23. Signature R.W. Williams (M. D. or other) _____
Address Moberly Mo. Date signed 10-30-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 11-43-1885

Date Filed NOV 16 1943

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Moherly 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1000

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dore Common Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 hrs. (Specify whether
In this community 7 1/2 w. years, months or days) (Specify whether

3. (a) PRINT FULL NAME

Charles F. Staiger

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 19 - (Month) (Day) (Year)

8. AGE: Years 90 Months 6 Days _____ If less than one day _____ min.

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

Ohio (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

_____ (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

_____ (State or foreign country)

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

_____ (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) _____ (b) _____ (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 Oct. Day 29 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) Hypostatic pneumonia Duration _____

fracture R. femur just below neck of femur. Accident

Due to _____

Due to _____ happened in his own back yard 10-2-1943

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) Fell in back yard

(b) Date of occurrence 10-3-1943

(c) Where did injury occur? Moberly Randolph Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Stumbled & fell in his back yard (Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature R.H. Williams (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

STATE VITAL RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. _____
Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name _____)

(If not in hospital or institution, write street no. _____)

(b) Length of stay: In hospital or institution _____

In this community _____
years, months or days

3. (a) PRINT
FULL NAME _____

3. (b) If sex _____

38975