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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 28 1944

Primary Registration District No. 3017

Registrar's No. 117

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

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'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 WEEKS
(Specify whether)

In this community LIFE
(years, months or days)

3. (a) PRINT FULL NAME MISS MOLLIE ANN STEGNER

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife

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

7. Birth date of deceased JANUARY 31 1966
(Month) (Day) (Year)

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

78 8 13 hr. min.

9. Birthplace COOPER COUNTY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

12. Name NICHOLAS STEGNER

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

14. Maiden name MARGARET BROWN

15. Birthplace COOPER COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MARION STEGNER

(b) Address BOONVILLE, Mo.

17. (a) BURIAL (b) Date thereof OCT. 15, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOORE CEMETERY

18. (a) Signature of funeral director STEGNER & KOENIG

(b) Address BOONVILLE, MO.

19. (a) Oct-14-44 (b) Dr Chas Swap
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER

(c) City or town PALESTINE TOWNSHIP
(If outside city or town limits, write "RURAL")

(d) Street No. 10 MILES SOUTH
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 13th
year 1944 hour 10:45 minute A.M.

21. I hereby certify that I attended the deceased from Sept 11, 1944, to Oct 13, 1944
that I last saw her alive on Oct 13, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death acute Enteritis Duration 7 days

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Other conditions Fracture Right hip 8-28-44
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Of operations none

Of autopsy General smile changed

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? S. D.
(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 T. G. Beckett (M. D. or other)
Address Boonville mo Date signed 10-14-44

107

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8

District File Number
Filed 11-1-11

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

James W. Stegner

Licensed Embalmer No.

3780

P.O. Address

Boonville, 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. Nov

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 117

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Mollie A. Stegner

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

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

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

7. Birth date of deceased Jan 3 (Month) (Day) (Year)

8. AGE: Years 78 Months 8 Day _____ If less than one day _____ min.

9. Birthplace 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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (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 Nov Day 18 Year 1944 Minute _____ M. _____

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

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death acute enteritis Duration _____

Due to _____

Due to _____

Other conditions Fracture right hip (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy General Semelchany

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

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

(b) Date of occurrence 8-28-44

(c) Where did injury occur? Boonville Cooper mo (City or town) (County) (State)

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

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

23. Signature J.C. Beckett (M.D. or other)

Address Boonville mo Date signed 11-4-44

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

SUPPLEMENTAL

34086