

**FILED NOV 25 1946**

Primary Registration District No. **3017-**

Registrar's No. **124**

**1. PLACE OF DEATH:**

(a) County Cooper

(b) City or town Bonville  
(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, give street number or location)

(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)

In this community 59 yrs 11 mo 2 da

**3. (a) PRINT FULL NAME:** MARY STOECKLEIN

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

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

6. (b) Name of husband or wife Frank Stoeklein 6. (c) Age of husband or wife if alive 11 years

7. Birth date of deceased Dec 11 1896  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>59</u>	<u>11</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace Cooper Co. Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Same

**MOTHER FATHER** { 12. Name Jacob Messias

{ 13. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

{ 14. Maiden name Anna Kraus

{ 15. Birthplace Cooper Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Joseph Stoeklein

(b) Address Pilot Home, Mo.

17. (a) Buried (b) Date thereof 11-16-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pilot Home Beth. Home.

18. (a) Signature of funeral director Hays - Painter

(b) Address Pilot Home, Mo.

19. (a) 11-13-46 (b) Stoeklein  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Cooper

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 13 year 1946 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 9, 1946, to Nov 13, 1946, that I last saw her alive on Nov 12, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Central Embolism

Due to Clot Separation - Thrombosis  
Varicosis legs

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

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 83B

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. H. Reigler (M. D. or other) M.D.

Address Bonville Mo. Date signed 11/13/46

Duration \_\_\_\_\_

Years \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

35664

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-23-46

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 Myself

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed Clayton E. Haro

Licensed Embalmer No. 2074

P. O. Address Juliet Grove, 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.)

<sup>3</sup> If this body is not embalmed, fact should be so stated above.