

FILED SEP 20 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 31465

7944

Registrar's No.

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Missouri Pacific Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 days  
 (Specify whether  
 In this community Life  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1019 Louisville  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Judith Stotler

3. (b) If veteran, name war No

3. (c) Social Security No. \_\_\_\_\_

4. Sex F Color or race W  
 6. (a) Single, widowed, married, divorced 50

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_ years

7. Birth date of deceased Aug 27 1939  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
9 0 11 hr. min.

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

10. Usual occupation Child

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

12. Name Marvin Stotler

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

14. Maiden name Maye Moore

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

16. (a) Informant Marvin M. Stotler

(b) Address 1019 Louisville Ave

17. (a) Burial (b) Date thereof 9/10/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc.

(b) Address 6633 Clayton Road

19. (a) SEP 10 1948 (b) J. F. Brundage  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8  
 year 1948 hour 3 minute 20 P.M.

21. I hereby certify that I attended the deceased from 1 Sept  
 \_\_\_\_\_, 1948, to 8 Sept, 1948,  
 that I last saw her alive on 8 Sept, 1948,  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Asystole of Rt Lobe of cerebellum

Due to Post-operative Intracranial pressure

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

Other conditions None  
 (Include pregnancy within 3 months of death)

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

Of autopsy Same

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 Royall Taylor (M. D. brother)  
 Address 462 N. Taylor Date signed 9/9/48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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 *Ernest W. Spillera*

Licensed Embalmer No. *H 080*

P. O. Address.....

**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.**