

FILED MAY 26 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18359

State File No. 14

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 349 PRIMARY REG. DIST. NO. 4514 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City 7</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>	
c. LENGTH OF STAY (in this place) <u>14 year</u>		d. STREET ADDRESS (If rural, give location) <u>No street address</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Home in Green City</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Lyman</u> b. (Middle) <u>Charles</u> c. (Last) <u>Stahl</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 17, 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 21, 1859</u>
9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Joseph Stahl</u>		13b. MOTHER'S MAIDEN NAME <u>Sofia Rankie</u>	
14. NAME OF HUSBAND OR WIFE <u>Ella May Stahl</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Myrtle Gusamer</u>		ADDRESS <u>Green City, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary sclerosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophy of prostate</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u> <u>4 1/2</u> <u>5 years</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 18, 1942</u> , to <u>May 17, 1949</u> , that I last saw the deceased alive on <u>May 17, 1949</u> , and that death occurred at <u>10 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>R.D. Smith D.O.</u>		23b. ADDRESS <u>Green City, Mo</u>	
23c. DATE SIGNED <u>5/20/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 20, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Green City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>May 21-1949</u>		REGISTRAR'S SIGNATURE <u>Laura Ballinger</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn E. Kent</u>		ADDRESS <u>Green City, Mo</u>	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 1

District File Number 5-49.1

Date Filed MAY 25 1949

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 \_\_\_\_\_

Carl R. Kent

Student Embalmer No. 243

working under my personal supervision.

Signed \_\_\_\_\_

Carl R. Kent  
Student Embalmer

Signed \_\_\_\_\_

Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address \_\_\_\_\_

Green City, 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.