

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19216

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 524

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) Springfield c. LENGTH OF STAY (In this place) 8 hrs.		c. CITY (If outside corporate limits, write RURAL and give township) Miller	
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)	a. (First) Zella	b. (Middle)	c. (Last) Stahl	4. DATE OF DEATH (Month) (Day) (Year) June 13 1949
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH June 9, 1891	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing	10b. KIND OF BUSINESS OR INDUSTRY NURSE	11. BIRTHPLACE (State or foreign country) Lawrence County	12. CITIZEN OF WHAT COUNTRY? Amer. USA
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13a. FATHER'S NAME Wm Robert Stahl	13b. MOTHER'S MAIDEN NAME Laura Stahl	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Belva Hanson	ADDRESS Madison Mo Rt 2
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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		INTERVAL BETWEEN ONSET AND DEATH 3
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary sclerosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION --	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **on June 13, 1949, only**, 19____, that I last saw the deceased alive on **6/13/49**, 19____, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE J. B. Lemmon, M.D. (Degree or title)	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 6/15/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-16-49	24c. NAME OF CEMETERY OR CREMATORY Stahl	24d. LOCATION (City, town, or county) (State) S. W. 7 Miller Mo.
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DATE REC'D BY LOCAL REG. 6/17/49	REGISTRAR'S SIGNATURE W. E. Handley	25. FUNERAL DIRECTOR'S SIGNATURE J. B. Lemmon	ADDRESS Miller Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

39
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JUN 24 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed S. B. Seiman

Signed _____
Student Embalmer

Licensed Embalmer No. 3297

P. O. Address Miller 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.