

No. 300
10. 48

FILED AUG 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24442**
Registrar's No. **133**

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 133		
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Charles				
b. CITY (If outside corporate limits, write RURAL and give town) St. Charles		c. LENGTH OF STAY (in this place) 12 hrs.		c. CITY (If outside corporate limits, write RURAL and give township) St. Peters Rural		1950		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospt.				d. STREET ADDRESS (If rural, give location) 1				
3. NAME OF DECEASED a. (First) John b. (Middle) Henry c. (Last) Stuckey			4. DATE OF DEATH (Month) (Day) (Year) July 29 1950					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH Nov. 15 1881		
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Grain & Stock		11. BIRTHPLACE (State or foreign country) St. Peters Mo. Rural		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME John Stuckey			13b. MOTHER'S MAIDEN NAME Newsteader		14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Mrs. Leo Fierling O'Fallon ADDRESS Mo.				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension (arteriosclerosis) DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 7201	
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) _____ m. _____		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 July 28, 1950, to July 29, 1950 , that I last saw the deceased alive on July 28, 1950 , and that death occurred at 6 a m., from the causes and on the date stated above.								
23a. SIGNATURE George R. Basaki M.D. (Degree or title)				23b. ADDRESS O'Fallon, Mo.		23c. DATE SIGNED 7-31-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 1 '50		24c. NAME OF CEMETERY OR CREMATORY All Saints		24d. LOCATION (City, town, or county) (State) St. Peters Mo.		
DATE REC'D BY LOCAL REG. 8/2/50		REGISTRAR'S SIGNATURE Frankie Hamilton		25. FUNERAL DIRECTOR'S SIGNATURE Earl Keithly ADDRESS O'Fallon Mo.				

(Licensed Embalmer's Statement on Reverse Side)

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

9230

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 E. Kerthly

Signed _____
Student Embalmer

Licensed Embalmer No. 824

P. O. Address J. Fallon 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.