

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34691**

FILED OCT 9 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>2636</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Manchester</u>		c. LENGTH OF STAY (In this place) <u>11 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Central</u> <u>0360</u> <u>1</u>				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Pine Crest Home, Div. 2</u>				d. STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Henry</u>			b. (Middle) <u>NMI</u>		c. (Last) <u>Stager</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9</u> <u>29</u> <u>53</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct. 28, 1874</u>		9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 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>Farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Robertsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Wm. Stager</u>			13b. MOTHER'S MAIDEN NAME <u>Kundia Banter</u>		14. NAME OF HUSBAND OR WIFE <u>Amelia Stager</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Amelia Stager St. Clair, 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>CEREBRAL HEMORRHAGE</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>9-24-53</u> <u>331X</u>	
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>		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. <u>—</u>		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>SEPT 18, 1953</u> , to <u>SEPT. 29, 1953</u> , that I last saw the deceased alive on <u>SEPT. 29, 1953</u> , and that death occurred at <u>8:40 p. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>B. P. Loving M.D.</u>				23b. ADDRESS <u>BALLWIN, MO.</u>		23c. DATE SIGNED <u>10-1-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>10-2-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Lonedell, Mo</u>			
DATE REC'D BY LOCAL REG. <u>10/1/53</u>		REGISTRAR'S SIGNATURE <u>Heather B. Somke M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Casey L. Lewis</u>		ADDRESS <u>St. Clair MO</u>		

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

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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.

Student

Student Embalmer

Signed

K. M. Leno

Licensed Embalmer No. *3601*

P. O. Address *St. Clair, 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.