

FILED JAN 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 173

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 2

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> | | c. CITY OR TOWN <u>Columbia</u> | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | e. STREET ADDRESS (If rural, give location) <u>1107 West Worley</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1107 West Worley</u> | | | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>WILLIAM</u> | b. (Middle) <u>AUGUSTUS</u> | c. (Last) <u>STAHL</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 1, 1954</u> |
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| 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>June 6, 1874</u> | 9. AGE (In years last birthday) <u>79</u> | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | IF UNDER 15 MIN. Mins. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cabinet Maker</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>Sedalia, Missouri.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Samuel Stahl</u> | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Unkifer</u> | 14. NAME OF HUSBAND OR WIFE <u>Annie E. Chambers Stahl</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. _____ | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Wm. A. Stahl, Columbia, Mo.</u> | ADDRESS _____ |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>sub to death</u> | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> | | | 22 mos. |
| | DUE TO (c) _____ | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION <u>4200</u> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) | 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 April 9, 1952, to 1-1, 1954, that I last saw the deceased alive on Dec 9, 1953, and that death occurred at 7:00A m., from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) <u>James W. Allie M.D.</u> | 23b. ADDRESS <u>Columbia Mo</u> | 23c. DATE SIGNED <u>1-2-54</u> |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>Jan. 3, 1954</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Columbia, Missouri.</u> |
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| DATE REC'D BY LOCAL REG. <u>Jan. 2 1954</u> | REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Parmer Funeral Service</u> | ADDRESS <u>Columbia, Mo</u> |
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WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
JWP Phillips

Licensed Embalmer No. 489

P. O. Address Columbia, N.Y.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.