

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10. 48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Callaway</u>	
b. CITY OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Fulton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>24 hrs.</u>		e. STREET ADDRESS (If rural, give location) <u>RFD 5 Fulton, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		f. ADDRESS <u>0140</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Virgil</u> b. (Middle) <u>Alvin</u> c. (Last) <u>STOCKHORST</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 12 56</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>June 9 1937</u>
9. AGE (In years last birthday) <u>18</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer at State Hospital</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Montgomery Co., Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Alvin Stockhorst</u>	
13b. MOTHER'S MAIDEN NAME <u>Vernonica Van Rooven</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>488-38-2999</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Alvin Stockhorst</u> ADDRESS <u>Rt 5 Fulton 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral concussion and contusion, severe</u> ANTECEDENT CAUSES <u>Automobile accident</u> Morbidity 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.	
19a. DATE OF OPERATION <u>2/12/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>Contused &amp; swollen brain</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>37 hrs</u>	
21a. ACCIDENT SUICIDE, HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>highway</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Fulton Callaway Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Feb. 11 1956 2a.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Automobile went out of control.</u>
22. I hereby certify that I attended the deceased from <u>2/11/56</u> , 19 <u>56</u> , to <u>2/12/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/12/56</u> , 19 <u>56</u> , and that death occurred at <u>3:10 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Samuel P. W. Black MD</u> (Degree or title)		23b. ADDRESS <u>University Hospital Columbia, Mo.</u>	23c. DATE SIGNED <u>2/12/56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 15 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Callaway Memorial Gardens Fulton, Mo.</u>	
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home</u> ADDRESS <u>Fulton, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Feb. 12 1956</u>	REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</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.....  
Signature of Student Embalmer

Signed *David C. Browning*.....

Licensed Embalmer No. *2422*  
P. O. Address *Fulton*.....

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.