

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 23 1956

State File No. **15948**

BIRTH NO. _____ REG. DIST. NO. **101** PRIMARY REG. DIST. NO. **5406** Registrar's No. **29**

1. PLACE OF DEATH a. COUNTY Seymour		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Seymour	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SEYMOUR Lincoln		c. CITY OR TOWN SEYMOUR	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0340	

3. NAME OF DECEASED (Type or Print)	a. (First) JOHN	b. (Middle)	c. (Last) STENGLE	4. DATE OF DEATH (Month) (Day) (Year) APR 21 1956
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 12 1891	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING	10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (City and State or Foreign Country) OTTAWA KANSAS	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME JOSEPH STENGLE	13b. MOTHER'S MAIDEN NAME ANNA UNKNOWN	14. NAME OF HUSBAND OR WIFE LAURA ETHEL STENGLE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME LAURA ETHEL STENGLE	ADDRESS SEYMOUR MO.
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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 2 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Gastric Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Stomach 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	19b. MAJOR FINDINGS OF OPERATION 151x	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) 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **4:15P** m., from the causes and on the date stated above.

23a. SIGNATURE M. C. Gentry (Degree or title) M.D.	23b. ADDRESS Ava Mo	23c. DATE SIGNED 4-24-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4/24 1956	24c. NAME OF CEMETERY OR CREMATORY PLEASANT RIDGE	24d. LOCATION (City, town, or county) (State) SE AVA MO
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DATE REC'D BY LOCAL REG. Apr. 17-56	REGISTRAR'S SIGNATURE Walter Bushman	25. FUNERAL DIRECTOR'S SIGNATURE CLINKINGBEARD FUNERAL HOME	ADDRESS AVA MO.
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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 *Charles R. Fish*.....

Licensed Embalmer No. *46*.....

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