

FILED OCT 8 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31808

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 236

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>	c. LENGTH OF STAY (in this place) <u>1 week</u>	c. CITY OR TOWN <u>St. Peters, rural</u>	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 <u>St. Joseph Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>2 miles west onb Sattler Rd.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mathilda</u> b. (Middle) _____ c. (Last) <u>Stuckey</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30, 1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct. 24, 1863</u>	9. AGE (In years last birthday) <u>92</u>	10. UNDER 1 YEAR Months <u>11</u> Days <u>17</u>	11. UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Peters, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Moritz Neustadter</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John A. Stuckey</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. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hilary Stuckey, RR, O'Fallon, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>		<u>Unknown</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____		<u>Unknown</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION _____	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) _____	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 Sept. 24, 1956, to Sept. 30, 1956, that I last saw the deceased alive on Sept. 30, 1956, and that death occurred at 7:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Don L. Randall, M.D.</u>	23b. ADDRESS <u>207 N. 5th St. Charles, Mo.</u>	23c. DATE SIGNED <u>Oct. 3, 1956</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>Oct. 3, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Peters, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 3 1956</u>	REGISTRAR'S SIGNATURE <u>Francis Hamster</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Theigater</u>	ADDRESS <u>St. Peters, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

28 4

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 *E. A. Keithly* .....

Licensed Embalmer No. *827* .....

P. O. Address *Fallon* .....

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.