

FILED SEP 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34176  
STATE FILE NUMBER  
1003  
Registrar's No. 8678

Registration District No. 31c Primary Registration District No. 1003 Registrar's No. 8678

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			c. CITY OR TOWN Blue Springs Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in 1b		STREET ADDRESS (If outside, give location) 231 Route # 2 Box 414 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annunziata Stadler			4. DATE OF DEATH Month Day Year Sept. 14, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1879	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Florence, Italy.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Philip DelBigio		13b. MOTHER'S MAIDEN NAME ( Unknown)		14. NAME OF HUSBAND OR WIFE Carl Stadler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No. Nil.		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Carl Stadler, Blue Springs, Missouri.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Colon (Recto sigmoid)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>abt 1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>153x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8/27/57</u> to <u>9/4/57</u> and last saw her alive on <u>9/12/57</u> Death occurred at <u>6:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Sam F. Beam M.D.</u> (Degree or title)			22b. ADDRESS <u>35 So Central - 5 -</u>		22c. DATE SIGNED <u>9/16/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <u>9-11-57</u>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Blue Springs, Missouri.</u>	
24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington,		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>SEP 16 57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>mjs</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

LOAN 15,000

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. J. Remelick

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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.