

with, welfare, public, advice

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009119  
STATE FILE NUMBER

FILED APR 8 1958

Registration District No. 389 Primary Registration District No. 5159 Registrar's No. 8

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1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Illinois</b> b. COUNTY <b>Alexander</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Caldwell Twp.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Cairo</b> <b>8120</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>Hiway 54 South</b>		Length of stay in lb <b>nil</b>	d. STREET ADDRESS (If outside, give location) <b>815 26th St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Foster</b> Last <b>Stenzel</b>			4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1937</b>
9. AGE (In years, <sup>at</sup> birthday) <b>21</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during immediately preceding life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>	11. BIRTHPLACE (City and state or country) <b>Cairo Illinois /</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Lee P. Stenzel</b>	
13b. MOTHER'S MAIDEN NAME <b>Gertrude Foster</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, if unknown) <b>ROTC</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>326 30 9078</b>	17. INFORMANT Address <b>Lee P. Stenzel Cairo Illinois.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skull Fracture- Brain Damage</b>			INTERVAL BETWEEN ONSET AND DEATH
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) <b>Fracture Right and Left Jaw Fracture Many Bones in face.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>One car accident on hiway 54 at Hillers creek.</b>	
20c. TIME OF INJURY <b>9:45 p.m. 3/21/58</b>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hiway</b>	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY <b>Callaway</b> STATE <b>Mo.</b> <b>Hiway 54 at Hillers cr.</b>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <b>9:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Wm. A. Stewart</b> (Degree or title) <b>Coroner</b>		22b. ADDRESS <b>Fulton Missouri</b>	22c. DATE SIGNED <b>3/22/58</b>
23a. BURIAL, CREMATION, ENOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Mem. Garden</b>	23d. LOCATION (City, town, or county) (State) <b>Villa Ridge Illinois</b>
24. FUNERAL DIRECTOR <b>Maupin Funeral Home Fulton Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-1-58</b>	26. REGISTRAR'S SIGNATURE <b>LeRoy Claypool</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 8 1958

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 *J. J. Ross*  
Licensed Embalmer No. *2555*

P. O. Address *Fullerton*

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.