

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-024597

FILED AUG 4 1958

STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 29

300
1-570
160
4

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Centralia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Centralia</u> <u>1100</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Way Nursing Home</u>		Length of stay in 1b <u>1 year</u>	d. STREET ADDRESS (If outside, give location) <u>329 S. Allen</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward John Stauterman</u>			4. DATE OF DEATH Month Day Year <u>July 31, 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1865</u>
9. AGE (In years last birthday) <u>92</u>		FUNDER 1 YEAR Months <u>8</u> Days <u>13</u>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Adams County, Ills. 1</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Peter Stauterman</u>	
13b. MOTHER'S MAIDEN NAME <u>Caroline Veihl</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Eliza (Deceased)</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>No</u>	17. INFORMANT Address <u>Mrs. A. Stauterman, Centralia, Mo.</u>
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>Chronic Myocarditis & Myocardial Degeneration (NOT Rheumatic)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u> <u>years</u> <u>years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Renal Syndrome</u>			
DUE TO (c) <u>Atherosclerotic Heart & Coronary</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>7-1-57</u> to <u>7-31-58</u> and last saw him alive on <u>7-31-58</u> Death occurred at <u>7:10 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr.</u>		22b. ADDRESS <u>Centralia Mo</u>	22c. DATE SIGNED <u>8-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>August 2, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centralia</u>	23d. LOCATION (City, town, or county) (State) <u>Centralia, Mo.</u>
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Centralia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 1 - 1958</u>	26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

AUG 8 1958

Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.

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 *Bill J. Meador*

Licensed Embalmer No. *4896*

P. O. Address: *Central, Mexico*

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.