

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028472

STATE FILE NUMBER

428

FILED AUG 25 1958

Registration District No. 53

Primary Registration District No.

Registrar's No.

S. 300
v. 1-57
4

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Cape Girardeau</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>Nursing Home</u>		Length of stay in lb <u>1 yr.</u>		d. STREET ADDRESS (If outside, give location) <u>1018 Independence St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>SOPHIA</u> Middle <u>M.</u> Last <u>STOVALL</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1958</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 9, 1870</u>		
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
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>Own home</u>		11. BIRTHPLACE (City and state or country) <u>Marble Hill, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Abraham Sitzes</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Haynes</u>			14. NAME OF HUSBAND OR WIFE <u>L. G. Stovall</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 <u>Loren Hopper</u> Address <u>Cape Girardeau, 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>Cerebrovascular Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>332 X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic + Hypertensive Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>unknown</u>		
20a. ACCIDENT <input 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 _____ a.m. _____ p.m.								
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>Jan., 1956</u> to <u>Aug. 9, 1958</u> and last saw her alive on <u>Aug. 3, 1958</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Israel M. Hotworsh, M.D.</u> (Degree or title)				22b. ADDRESS <u>24 N. Spring Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>8/11/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug. 10, 1958</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cape Girardeau, Missouri</u>		
24. FUNERAL DIRECTOR <u>Walther's Funeral Home</u> ADDRESS <u>Cape Girardeau, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Aug 15, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Homer Cooper</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Virgil H. Welch*

Licensed Embalmer No. *4102*

P. O. Address *Cap. Seward*

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.