

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029682

STATE FILE NUMBER

FILED SEP 9 1958 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 286

S. 300
1-57

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

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u> <u>06440</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>Levering Hospital</u>			Length of stay in 1b <u>8/19/58</u>	d. STREET ADDRESS (If outside, give location) <u>716 Hawkins</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M</u> Last <u>STOOPS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>September 7, 1864</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>19</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>Painter Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>John Stoops</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Marshall</u>		14. NAME OF HUSBAND OR WIFE <u>Sadie F. Stoops (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></u>	17. INFORMANT <u>Henry A. Stoops, Hannibal Missouri</u>			Address <u></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>cerebral vascular accident, acute</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <u>generalized arteriosclerosis, especially cerebral</u>	
						DUE TO (c) <u>urinary retention, acute secondary to CA prostate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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.) <u>331XH</u>				
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>							
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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u> STATE <u></u>	
21. I attended the deceased from <u>3-24-58</u> to <u>8-22-58</u> and last saw her alive on <u>8-22-58</u> Death occurred at <u>10:40 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>F. E. Sultzman M.D.</u>				22b. ADDRESS <u>115 N. 5th St. Hannibal, Mo.</u>		22c. DATE SIGNED <u>8-25-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/25/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olive Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
24. FUNERAL DIRECTOR <u>W. Crawford Smith Hannibal Missouri</u>			ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>9-2-58</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke By W. C. Fisher</u>		

RECEIVED SEP 8 1958
MARION CO. HEALTH DEPT.
DATE FILED SEP 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 *John S. Stand*

..Licensed Embalmer No.....4540.....

P. O. Address...Hannibal Missouri

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.