

pt. Health,
, & Welfare
S. Public
with Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040999

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 461

S. 300
ev. 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
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sedalia</u> ⁰⁸⁰⁴		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>Sedalia Rest Home</u>		Length of stay in 1b <u>14 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>2500 So. Grand</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>Stohr</u> Last <u>Stohr</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>7</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"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1974</u>		9. AGE (In years last birthday) <u>84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Cole Camp Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>John Stohr</u>		13b. MOTHER'S MAIDEN NAME <u>Schuber</u>	
14. NAME OF HUSBAND OR WIFE <u>Katherine</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Victor Stohr</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>Myocarditis & Myocardial Degeneration</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443X</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>years</u> <u>years</u>	
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.)	
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <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 <u>Sedalia</u>		COUNTY <u>Pettis</u>		STATE <u>Mo</u>	
21. I attended the deceased from <u>10-4-1952</u> to <u>12-7-1958</u> and last saw ^{the} him alive on <u>12-7-1958</u> Death occurred at <u>3:10 AM</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>DD</u>		22b. ADDRESS <u>Woodland Hosp. Sedalia</u>	
22c. DATE SIGNED <u>12-8-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-9-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Peters & St Pauls</u>		23d. LOCATION (City, town, or county) <u>Cole Camp</u>		(State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>M^o Laughlin Bros</u>		ADDRESS <u>Sedalia</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-1958</u>	
26. REGISTRAR'S SIGNATURE <u>Frances A Kelly</u>					

(Licensed Embalmer's Statement on Reverse Side)

VS SEP 23 1959

VS OCT 1 1959

VS SEP 21 1959

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.P.M. Leary*

Licensed Embalmer No. *3153*
P. O. Address *Sedalia 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.