

FILED JAN 15 1959

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REG.#17509

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000420
STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY BUTLER			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BOLLINGER		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN SEDGEWICKVILLE		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS HOSPITAL		Length of stay in 1b 57 DAYS	d. STREET ADDRESS (If outside, give location) NONE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle WALKER Last STATLER			4. DATE OF DEATH Month JANUARY Day 2 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/25/97		9. AGE (In years last birthday) 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) SEDGEWICKVILLE, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JOHN STATLER		13b. MOTHER'S MAIDEN NAME JANE SEABAUGH		14. NAME OF HUSBAND OR WIFE CORA STATLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH ANGINA PECTORIS, VARIABLE CONDUCTION DEFECTS.					INTERVAL BETWEEN ONSET AND DEATH Sev. Years.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SINUS BRADYCARDIA; STOKES-ADAMS SYNDROME, AURICULAR FIBRILLATION AND PROBABLE VENTRICULAR TACHYCARDIA.					Sev. Years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE.					Sev. Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PYELONEPHRITIS, CHRONIC, RECURRENT.					19. WAS AUTOPSY PERFORMED? NO 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 _____ Month _____ Day _____ Year _____ 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. attended the deceased from Nov. 6, 1958 to Jan. 2, 1959 Death occurred at 12:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Deceased or proxy) Robert S. Cohen ROBERT S. COHEN, M.D., Chief, Med. Svc.			22b. ADDRESS VA Hospital, Poplar Bluff, Mo.		22c. DATE SIGNED 1/2/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-2-59	23c. NAME OF CEMETERY OR CREMATORY Sedgewickville Cem.		23d. LOCATION (City, town, or county) (State) Sedgewickville, Mo.
24. FUNERAL DIRECTOR Frank-Cotrell Poplar Bluff, Mo.		25. DATE RECD. BY LOCAL REG. 1/10/59		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Charles E. Murphy

Licensed Embalmer No. 487

P. O. Address 170 Bay 13

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.