

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006726

STATE FILE NUMBER

FILED FEB 16 1959 Registration District No. 295 Primary Registration District No. 6015 Registrar's No. 4

300
-57

1. PLACE OF DEATH a. COUNTY Salt Spring Twp. <i>Randolph</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY <i>Chariton</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Huntsville</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Salisbury</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Pleasant View</i>		Length of stay in lb <i>1 weeks</i>	d. STREET ADDRESS (If outside, give location) <i>207 East Second St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Lawrence Roscoe Stodgell</i>			4. DATE OF DEATH Month Day Year <i>2 12 1959</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 29, 1872</i>		9. AGE (In years (Day birthday) MONTHS DAYS HOURS MIN. <i>87</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>gen. farming</i>		11. BIRTHPLACE (City and state or country) <i>Mo. of Salis. Chariton, Co. U.S.A.</i>	
13a. FATHER'S NAME <i>Chasteen Stodgell</i>		13b. MOTHER'S MAIDEN NAME <i>Sarah Landsdown</i>		14. NAME OF HUSBAND OR WIFE <i>Ida Sanders Stodgell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs. Ida Stodgell</i> Address <i>207 E. 2nd St. Salisbury, Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of h. Hip</i>					INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<i>9027</i>
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.) <i>Fall at Pleasant View Home - getting out of bed</i>		
20c. TIME OF INJURY Hour Month, Day, Year <i>6 a.m. 1/22/59</i>					
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.) <i>Pleasant View Home</i>		20f. CITY, TOWN, OR LOCATION <i>Huntsville</i> COUNTY <i>Randolph</i> STATE <i>Mo.</i>	
21. I attended the deceased from <i>1/22/59</i> to <i>2/9/59</i> and last saw him alive on <i>2/9/59</i> Death occurred at <i>10 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>D. Dreyer MD</i> (Degree or title)			22b. ADDRESS <i>Huntsville, Mo.</i>		22c. DATE SIGNED <i>2/13/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-11-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Prairie Valley Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Chariton County, Mo.</i>
24. FUNERAL DIRECTOR <i>Chas B Winckelmyer</i> ADDRESS <i>Salisbury, Mo</i>			25. DATE REC'D BY LOCAL REG. <i>2/13/1959</i>		26. REGISTRAR'S SIGNATURE <i>Wm. H. ...</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Chas B. Winikelmeyer*

Licensed Embalmer No. *3842*

P. O. Address *Salisbury, Md.*

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.