

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009906

STATE FILE NUMBER

FILED MAR 27 1959

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 59

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		c. CITY OR TOWN Carthage	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks Hospital		d. STREET ADDRESS (If outside, give location) Fair Acres, Carthage, Mo. Route #3	
3. NAME OF DECEASED (Type or print) First Middle Last Kate Stohl		4. DATE OF DEATH Month Day Year March 16, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1875
9. AGE (In years birthday) 84		10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and state or country) Hungary Europe 4
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME John Mastis	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Carl Stohl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Fair Acres, Carthage, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 420! PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Day or two Unknown.
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. I attended the deceased from 8-27-55 to 3-16-59 and last saw her alive on 3-16-59 Death occurred at 9:40 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lester A. Peterson MD		22b. ADDRESS Carthage, Mo.	22c. DATE SIGNED 3-16-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-19-59	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery	23d. LOCATION (City, town, or county) (State) Carthage, Mo.
24. FUNERAL DIRECTOR ADDRESS Knell Mortuary, Carthage, Mo.		25. DATE RECD. BY LOCAL REG. 3-18-59	26. REGISTRAR'S SIGNATURE Ely Clinton

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 *O. L. Isbell*

Licensed Embalmer No. *4970*

P. O. Address *Carthage, 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.