Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012102
STATE FILE NUMBER

FILED MAR 24 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 42

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) State Hospital #3 — Length of stay in 1b 28yr 11mo 1wk

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2025 Alberta — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First PEARL Middle E. Last STAGNER
4. DATE OF DEATH Month 3 Day 11 Year 59
5. SEX F.
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10/22/1892
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping
10b. KIND OF BUSINESS OR INDUSTRY Housekeeping
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME unknown
13b. MOTHER'S MAIDEN NAME unknown
14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT State Hospital 3 Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pernicious Anemia — INTERVAL BETWEEN ONSET AND DEATH months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Arteriosclerosis — years. 29CC
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/31/56 to 3/11/59 and last saw her alive on 3/11/59
Death occurred at 8:25 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE George Osker M.D. (Degree or title)
22b. ADDRESS State Hospital No. 3
22c. DATE SIGNED 3/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 3-12-1959
23c. NAME OF CEMETERY OR CREMATORY Swanwick Cemetery
23d. LOCATION (City, town, or county) Perry County (State) Ill.
24. FUNERAL DIRECTOR Eickinger Funeral Home ADDRESS Nevada, Mo.
25. DATE RECD. BY LOCAL REG. 3-20-1959
26. REGISTRAR'S SIGNATURE Omar E. Ferry

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

MAR 31 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 Percy P. McIlster

Licensed Embalmer No.....

P. O. Address.....

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.