

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020790

STATE FILE NUMBER

FILED JUN 29 1959 Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 83

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Boonville</u>			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>St. Joseph's Hosp.</u>			Length of stay in lb <u>2 days</u>		d. STREET ADDRESS (If outside, give location) <u>312 Walnut</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>CHRISTIAN</u> Last <u>STEGNER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1874</u>		9. AGE (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>George J. Stegner</u>			13b. MOTHER'S MAIDEN NAME <u>Patricia Dueschle</u>			14. NAME OF HUSBAND OR WIFE <u>Bibbie Jain Stegner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs Frank Stegner</u> Address <u>Boonville, Mo.</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>Stroke - Adams Syndrome</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease - Heart Block</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-3 months</u> <u>2 years</u>	
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 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		COUNTY STATE	
21. I attended the deceased from <u>JANUARY 16, 1956</u> to <u>JUNE 20, 1959</u> and last saw her/him alive on <u>JUNE 19, 1959</u> Death occurred at <u>4:20 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not print) <u>William A. Lebel, M.D.</u>				22b. ADDRESS <u>329 MAIN BOONVILLE, MISSOURI</u>		22c. DATE SIGNED <u>6-20-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>June 22, 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Boonville, Mo.</u>		
24. FUNERAL DIRECTOR <u>B. W. Thacher</u> ADDRESS <u>Boonville, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>6/22/59</u>		26. REGISTRAR'S SIGNATURE <u>W. Cooper</u>	

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

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 Berry W. Shaker

Licensed Embalmer No. 3944
P. O. Address Boonville, 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.