

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020847  
STATE FILE NUMBER

t. Health,  
, & Welfare  
S. Public  
th Service

FILED JUN 25 1959

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 39

S. 300  
v. 1-57

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

1. PLACE OF DEATH a. COUNTY <u>Dent</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springcreek Twsp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springcreek Twsp.</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>1 Mi no. Salem</u>		Length of stay in lb <u>4 years</u>	d. STREET ADDRESS <u>Bixby Rte, Salem</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVERETT</u> Middle <u>MANUEL</u> Last <u>STAGNER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>19</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 5 1885</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Works</u>	11. BIRTHPLACE (City and state or country) <u>Dent County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William M. Stagner</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Grider</u>		14. NAME OF HUSBAND OR WIFE <u>Sylvia Stagner</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>488 18 4021</u>	17. INFORMANT Address <u>Sylvia Stagner Bixby Rte, Salem, 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>cardio vascular renal disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. } DUE TO (b) _____						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not related to the terminal disease condition given in PART I (a)) <u>diabetes mellitus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 _____ a.m. _____ p.m. _____						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>1950</u> , to <u>6-19-59</u> and last saw <u>him</u> alive on <u>6-19-59</u> Death occurred at <u>6:45 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Joe D. Warfel, D.D. 2</u>			22b. ADDRESS <u>Salem, Mo.</u>		22c. DATE SIGNED <u>6-22-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/23/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dry Fork Cemetery</u>		23d. LOCATION (City, town, or county) <u>Dent County Missouri</u> (State)		
24. FUNERAL DIRECTOR <u>Max L. Warfel</u> ADDRESS <u>Salem, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/23/59</u>	26. REGISTRAR'S SIGNATURE <u>M. M. Warfel, M.D. by use</u>			

JUN 25 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 Max L. Warfel  
Licensed Embalmer No. 4170  
P. O. Address Salem, 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.