

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-027864

FILED VS JUL 27 1959

Registration District No. 581 Primary Registration District No. 6183 Registrar's No. 73

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Sullivan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Paik Sup</u> Length of stay in 1b _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u> c. CITY OR TOWN <u>Milan</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Gary</u> Last <u>Stiner</u>			<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>23</u> Year <u>59</u>				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-19-39</u>	<b>9. AGE (last birthday)</b> <u>20</u>	<b>IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>4</u>	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>student</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Middleburg Pa</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.</u>	
<b>13a. FATHER'S NAME</b> <u>Charles L Stiner</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Reba Mcclusky</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Marion Stiner - Kansas City Mo</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____			<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Marion Stiner - Kansas City Mo</u> Address _____		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electric Shock</u> DUE TO (b) <u>Contact with Electric wire</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Man in contact with live wire while riding autopsy house being moved</u>					
<b>20c. TIME OF INJURY</b> Hour <u>9:30</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year <u>7-23-59</u>		<b>20d. INJURY OCCURRED WHILE AT WORK?</b> YES <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Ms. Highway C.G.</u>		<b>20f. CITY, TOWN, OR LOCATION</b> <u>Milan</u> COUNTY <u>Sullivan</u> STATE <u>Mo</u>	
<b>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>E.W. Simpson DO</u> (Degree or title)				<b>22b. ADDRESS</b> <u>Milan Mo</u>		<b>22c. DATE SIGNED</b> <u>7-23-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>removal</u>		<b>23b. DATE</b> <u>7-23-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lock Haven Pa</u>		<b>23d. LOCATION</b> (City, town, or county) (State)		
<b>24. FUNERAL DIRECTOR</b> <u>Schuene's Milan Mo</u> ADDRESS _____			<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-24-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. M. W. Beckett</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6561 7 90V  
AUG 4 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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

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.