

Dept. Health,  
J. S. Public Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-039350  
STATE FILE NUMBER

FILED VS DEC 10 1959

Registration District No. 71 Primary Registration District No. 3017 Registrar's No. 118

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Colorado</u> b. COUNTY <u>Pueblo</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Pueblo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration INSTITUTION <u>tion Hospital</u>		Length of stay in lb <u>455 days</u>	d. STREET ADDRESS (If outside, give location) <u>1716 East Evans Ave</u>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>JOSEPH</u> Last <u>STEFANIC</u>			4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1906</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-----------------------	----------------------------------	---	---	--	--	--

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>Steel Mill</u>	11. BIRTHPLACE (City and state or country) <u>Pueblo, Colorado</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>John Stefanic</u>	13b. MOTHER'S MAIDEN NAME <u>Frances Banko</u>	14. NAME OF HUSBAND OR WIFE <u>- - -</u>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>	16. SOCIAL SECURITY NO. <u>317 09 8048</u>	17. INFORMANT <u>VA Hospital records</u>	Address
---	---	---	---------

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>Emphysema, obstructive and compensatory</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
---	--

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Tuberculosis, pulmonary, chronic, far advanced, active  
DUE TO (c) - - -

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
Enlargement of heart due to pulmonary disease  
Chronic pancreatitis due to infection

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
---

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.) <u>- -</u>
---	--

20c. TIME OF INJURY Hour <u>-</u> Month <u>-</u> Day <u>-</u> Year <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>- -</u>	20f. CITY, TOWN, OR LOCATION <u>- -</u>	COUNTY	STATE
---	---	--	--	--------	-------

21. I attended the deceased from <u>Aug. 27, 1958</u> to <u>Nov. 25, 1959</u> Death occurred at <u>10:20 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <u>F. MANTPELL, M.D., Acting Pathologist</u>	22b. ADDRESS <u>VAH, Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>11-27-59</u>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>UNKNOWN</u>	23d. LOCATION (City, town, or county) <u>PUEBLO, COLORADO</u>	(State)
---	------------------------------	--	--	---------

24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u>	ADDRESS <u>Excelsior Springs, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>12/4/59</u>	26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>
--	---	--	--

securing the medical certification in the specific manner required by 193.140 MoRS 1949. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

62-0

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 *Ralph Van Landingham*

Licensed Embalmer No. *4009*  
P. O. Address *Proctor, N.Y.*

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.