

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040741

FILED VS DEC 14 1959

Registration District No. 164 Primary Registration District No. 8032 Registrar's No. 160

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>		Length of stay in 1b <u>2 Das.</u>		c. CITY OR TOWN <u>Washington Twms.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Warrensburg Medical Center</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>10 Mi. SE of Odessa</u>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Samuel</u> Last <u>Stoll</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>8,</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>3-15-1890</u>			
				9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months _____ Days _____			
						IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Lafayette Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Julius Stoll</u>			13b. MOTHER'S MAIDEN NAME <u>Minnie Moran</u>			14. NAME OF HUSBAND OR WIFE <u>Margaret Stoll</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>494-40-4727</u>		17. INFORMANT Address <u>Mrs. Margaret Stoll, Odessa, 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>Coronary Artery Infarct</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
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)						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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
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>12-6-59</u> to <u>12-8-59</u> and last saw ^{her} him alive on <u>12-7-59</u> Death occurred at <u>1:20 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Phoe Cooper M D</u>				22b. ADDRESS <u>Warrensburg Mo</u>				22c. DATE SIGNED <u>12-8-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 10, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Odessa, Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Husman-Sparks, Odessa, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Dec. 8, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Lovannah Crutcherfield</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 William T. Sp

Licensed Embalmer No. 4431

P. O. Address Odessa

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.