

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 28 1960

82

Registration District No. _____ Primary Registration District No. 3017 Registrar's No. 63

60-010377

STATE FILE NUMBER

ENDED

| | | | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cooper</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cooper</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Boonville</u> | | Length of stay in 1b <u>50 yrs</u> | | 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 Hospital</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>1202 Main</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>WILLIAM</u> Last <u>STEGNER</u> | | | | 4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1960</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>1/27/87</u> | | 9. AGE (last birthday) <u>73</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>Retired Mgr.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>R R Express Co.</u> | | 11. BIRTHPLACE (City and state or country) <u>Billingsville, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME - <u>George Stegner</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Katheryn Westerman</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Laura Stegner</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes WWI</u> | | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | 17. INFORMANT Address <u>Mrs J. W. Stegner 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>Cerebrovascular accident</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cerebrovascular Disease</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>18 years</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) | | | | | | | | 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>3-17-60</u> to <u>3-21-60</u> and last saw ^{her} him alive on <u>3-20-60</u> Death occurred at <u>2:25 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>B. M. Stuart, M.D.</u> | | | | 22b. ADDRESS <u>329 Main, Boonville, Mo.</u> | | | | 22c. DATE SIGNED <u>3/21/60</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE <u>3/23/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Boonville, Missouri</u> | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>B. W. Thacher Boonville, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>3/21/60</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 3 1961

JAN 9 1961

APR

MAR 29 1960

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 Berry W. Shaker

Licensed Embalmer No. 3944

P. O. Address Doonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.