

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-027703

FILED VS AUG 5 1960

STATE FILE NUMBER

Registration District No. 230

Primary Registration District No. 4345

Registrar's No. 10

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RHINELAND</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>RHINELAND</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ <b>90</b>			Length of stay in lb _____	d. STREET ADDRESS <b>0700</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM - STIERS</b>				4. DATE OF DEATH Month Day Year <b>8 - 1 - 1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-20-1893</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANICAL WORK GARAGE OPERATOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BLUFFTON, MO.</b>	11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>WILLIAM STIERS</b>			13b. MOTHER'S MAIDEN NAME <b>MARTHA JANE QUICK</b>		14. NAME OF <del>husband</del> OR WIFE <b>BARBARA STIERS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-34-3953</b>	17. INFORMANT <b>Heron Stiers - Rhineland, Mo.</b>			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) <b>Acute Medullary failure</b>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral anoxia</b>							
DUE TO (c) <b>Coronary thrombosis 4201</b>						<b>3 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes, hypertension</b>						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 Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <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 <b>9/25/51</b> to <b>8/1/60</b> and last saw her alive on <b>8/1/60</b> Death occurred at <b>5:44 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>W. G. Jeter, M.D.</b> (Degree or title)				22b. ADDRESS <b>Hermann, Mo.</b>		22c. DATE SIGNED <b>8/2/60</b>	
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>8-4-60</b>	<b>Best Bottom</b>		<b>Rhineland, Mo.</b>			
24. FUNERAL DIRECTOR <b>Kattmeyer, Co. - Rhineland, Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>8/3/60.</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Eunice Bush</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by 193.140 MoKS 1949. 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.

44 4A  
AUG 10 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 me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *D B Baker* .....

Licensed Embalmer No. *3375* .....

P. O. Address. *New Haven* .....

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.