

**REGISTRATION DISTRICT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-030281**

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 926

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>SPRINGFIELD</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>ST. JOHN'S HOSP.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2008 S. JEFFERSON</b>

3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>J.</b> Last <b>STIEFVATER</b>			4. DATE OF DEATH Month <b>SEPT.</b> Day <b>3</b> Year <b>1960</b>			
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>1/22/77</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HARDWARE CO.</b>	11. BIRTHPLACE (City and state or country) <b>ST. NAZIANZE, WIS.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>JOHN STIEFVATER</b>	13b. MOTHER'S MAIDEN NAME <b>CATHERINE BENVERSY</b>	14. NAME OF HUSBAND OR WIFE <b>ROSA STIEFVATER</b>
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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>491-03-6974</b>	17. INFORMANT <b>ROSA STIEFVATER,</b>	Address <b>SPRINGFIELD, MD.</b>
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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>RUPTURE OF ANEURYSM OF LEFT ILLIAC ARTERY AT THE AORTIC BIFURCATION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>
DUE TO (b) <b>AORTIC SCLEROSIS DUE TO ARTERIOSCLEROSIS SEVERE</b>		
DUE TO (c) <b>AORTIC SCLEROSIS DUE TO ARTERIOSCLEROSIS SEVERE</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>	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
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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.) <b>NONE</b>
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20c. TIME OF INJURY Hour <b>NONE</b> a.m. p.m.	Month, Day, Year <b>NONE</b>
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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 <b>SPRINGFIELD, MO.</b>	COUNTY	STATE
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21. I attended the deceased from <b>SEPTEMBER 2</b> to <b>SEPT. 3RD</b> and last saw him alive on <b>SEPT. 3, 1960</b> Death occurred at <b>9:30 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>W. Paul, M.D.</i>	(Degree or title)	22b. ADDRESS <b>609 Cherry, Springfield, Mo.</b>	22c. DATE SIGNED <b>9/4/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8/6/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>SPRINGFIELD, MO.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>9-6-60</b>	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *A. J. Mc Conn*

Licensed Embalmer No. 272

P. O. Address *Springfield*

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