

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035630

LED VS SEP 29 1960

Registration District No. 257 Primary Registration District No. 5882 Registrar's No. 49

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Osage</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Osage</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koeltztown, Mo.</b>		Length of stay in 1b		c. CITY OR TOWN <b>Koeltztown</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>at home</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>WILLIAM STUMPE</b>				4. DATE OF DEATH <b>SEPT 25, 1960</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/9/75</b>		9. AGE (last birthday) <b>85</b>	
						IF UNDER 1 YEAR		IF UNDER 24 HR	
						Months		Days	
						Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME <b>William Stumpe</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Cunigunda Hilke</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.		17. INFORMANT <b>Raymond Stumpe Koeltztown, Mo.</b>				
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>Arteriosclerotic heart disease</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Obesity - Senility</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			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <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 <b>July 1957</b> to <b>Sept 24/60</b> and last saw her alive on <b>Sept 24/60</b> Death occurred at _____ <b>2 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Reagan A. Dayler</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>Jefferson City</b>				22c. DATE SIGNED <b>9-26-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/28/60</b>		23c. NAME OF CEMETERY OR CREMATOR <b>St Boniface</b>		23d. LOCATION (City, town, or county) <b>Koeltztown, Mo.</b>			
24. FUNERAL DIRECTOR <b>Sylvester Dulle</b> ADDRESS <b>JC Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>9/28/60</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Cayde Mostow</b>				

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed \_\_\_\_\_

*Sylvester R. Della*

Licensed Embalmer No. 432

P. O. Address Jeffersonville

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.