

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS OCT 31 1960

=60-037855  
STATE FILE NUMBER

Registration District No. 82 Primary Registration District No. 3017 Registrar's No. 154

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Cooper</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Cooper</b> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Boonville</b>                                 |  | Length of stay in 1b<br><b>All of life</b>  | c. CITY OR TOWN <b>Boonville</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>             |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>111 West Spring St.</b> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mattie</b> Middle <b>Stammerjohn</b> Last <b>Holtman</b>              |  |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>26</b> Year <b>1960</b>   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>                     | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 7, 1869</b>   | 9. AGE (last birthday)<br><b>91</b>   | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/>     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>       | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b> |   | 11. BIRTHPLACE (City and state or country)<br><b>Boonville, Missouri, USA</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                   |  |
| 13a. FATHER'S NAME<br><b>Claus Stammerjohn</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Emma Miller</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>J. Ed. Holtman</b>                        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br>-----  | 17. INFORMANT Address<br><b>Mrs. Emmarie Jonas, Boonville, Mo.</b>  |   |  |

|  |   |  |  |   |                                     |
|--|---|--|--|---|-------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocarditis</u>   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs</u>  |                                     |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |  |  |   |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Arteriosclerosis - Cerebral Degeneration</u>   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>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.) |  |   |                                     |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  |   |  |  |   |                                     |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Mar 10, 1960</u> to <u>Oct 26, 1960</u> and last saw her alive on <u>Oct 26, 1960</u><br>Death occurred at <u>7:40 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |  |   |                                     |
| 22a. SIGNATURE (Degree or title)<br><u>J.C. Beckett MD</u>   |   |  | 22b. ADDRESS<br><u>Boonville, Mo.</u>  |   | 22c. DATE SIGNED<br><u>10-28-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>Oct. 29, 1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Walnut Grove</b>                                    | 23d. LOCATION (City, town, or county) (State)<br><b>Boonville, Missouri.</b> |   |                                     |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Goodman &amp; Boller, Boonville, Mo.</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>10/29/60</b>  | 26. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                              |   |                                     |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 6 AON

**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 William W. Wood

Licensed Embalmer No. 4539

P. O. Address Boonville, Mo

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.