

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 21 1960

-60-041565

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 242

1. PLACE OF DEATH a. COUNTY FRANKLIN				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY GASCONADE									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		Length of stay in lb 3 1/2 hrs		c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1 mi. W. of HERMANN		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First EFFIE Middle ELLEN Last STOECKLIN				4. DATE OF DEATH Month NOV Day 15 Year 1960									
5. SEX FEMALE		6. COLOR OR RACE CAU.		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/10/1894		9. AGE (last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (City and state or country) CLINTON Mo		12. CITIZEN OF WHAT COUNTRY U.S.					
13a. FATHER'S NAME JOS. DAVIS				13b. MOTHER'S MAIDEN NAME UNKNOWN				14. NAME OF HUSBAND OR WIFE GEO. STOECKLIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT VIOLA WHITMAN		Address HERMANN Mo					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACURE OF SKULL WITH BAR-										INTERVAL BETWEEN ONSET AND DEATH 18 hrs?			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DURAL HEMORRHAGE													
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"/> N. <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input 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.) UNDETERMINED SUBJECT REPORTED TO HAVE STRIKING HEAD									
20c. TIME OF INJURY Hour AM a.m. p.m. Month, Day, Year 11/15/60		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.) FARM - ONE MILE W. HERMANN		20f. CITY, TOWN, OR LOCATION HERMANN		COUNTY GASCONADE		STATE MO			
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i>				22b. ADDRESS HERMANN Mo				22c. DATE SIGNED 11/15/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/18/60		23c. NAME OF CEMETERY OR CREMATORY HERMANN CEMETERY		23d. LOCATION (City, town, or county) HERMANN		(State) Mo					
24. FUNERAL DIRECTOR HUGO H. BLUMER				ADDRESS HERMANN Mo		25. DATE RECD. BY LOCAL REG. 11/15/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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 _____
Licensed Embalmer No. 3160

P. O. Address Hermann

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