

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-040569
STATE FILE NUMBER

AMENDED

Registration District No. 098 Primary Registration District No. _____ Registrar's No. 8

FILED NOV 22 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Washington Twp.</u>		c. CITY OR TOWN <u>Rural Edward Twp.</u>	
Length of stay in lb <u>Few Minutes</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 Mi. N.E. Jameson, Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>RFD. 2 Geneseo, Illinois</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Mason</u> Last <u>Stottler</u>			4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1961</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1899</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool Grinder</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Implement Factory</u>	11. BIRTHPLACE (City and state or country) <u>Hettick, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Y. Stottler</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret V. Webber</u>	14. NAME OF HUSBAND OR WIFE <u>Mable D. Stottler</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Mable Stottler</u> Address <u>Rt. 2 Geneseo, Illinois</u>
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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) <u>Extreme loss of Blood & Shock</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 Min.</u>
DUE TO (b) <u>Gunshot Wound Under left Arm, & Chest</u>		
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"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Leaned over to pick up Game he had shot</u>
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20c. TIME OF INJURY Hour <u>11:05</u> Month, Day, Year <u>11-11-1961</u>	and <u>12 Ga. Automatic Shotgun</u> was discharged
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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.) <u>On Farm while Hunting</u>	20f. CITY, TOWN, OR LOCATION <u>Rural Washington Twp.</u>	COUNTY <u>Daviess</u>	STATE <u>Mo.</u>
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21. I attended the deceased from At Death to _____, and last saw her/him alive on Did Not.
Death occurred at 11:25 A. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Harvey A. Roberson</u> (Degree or title) <u>Covered Davison Co</u>	22b. ADDRESS <u>Pattonburg, Missouri</u>	22c. DATE SIGNED <u>11-11-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-12-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenview Memorial Gardens Moline, Illinois</u>	23d. LOCATION (City, town, or county) (State) <u>Moline, Illinois</u>
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24. FUNERAL DIRECTOR <u>Hope Funeral Home,</u>	ADDRESS <u>Gallatin, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>15 Nov. 1961</u>	26. REGISTRAR'S SIGNATURE <u>Viggo M. Engstrand</u>
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(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF

NOV 2 1961 SA

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 L. O. Richesson

Licensed Embalmer No. 3302

P. O. Address Baltic, Va

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.