

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-045949

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 305P Registrar's No. 305

FILED DEC 28 1961

AMENDED

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		c. CITY OR TOWN <u>St Charles</u>	
Length of stay in lb <u>50 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>106 So. 3rd St</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>N.</u> Last <u>Stumberg</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1912</u>	9. AGE (last birthday) <u>48 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or of country) <u>St Charles Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John H. Stumberg</u>	13b. MOTHER'S MAIDEN NAME <u>Helene Linnemann</u>	14. NAME OF HUSBAND OR WIFE <u>None</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. <u>None</u>	17. INFORMANT <u>Henry K. Stumberg</u> Address <u>St Charles Mo</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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>		
DUE TO (c) <u> </u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① Myocardial infarction ② fracture left femur</u>	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 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>Fall, fracturing left femur and hip</u>
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20c. TIME OF INJURY Hour <u>2:00</u> p.m. Month, Day, Year <u>Dec 5, 1961</u>
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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>Home</u>	20f. CITY, TOWN, OR LOCATION <u>St Charles</u> COUNTY <u>St. Charles</u> STATE <u>Mo</u>
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21. I attended the deceased from Dec 1954 to Dec 15, 1961 and last saw her alive on Dec 15, 1961
Death occurred at 7:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ernest J. Conroy, M.D.</u> (Degree or title)	22b. ADDRESS <u>St. Charles, Mo</u>	22c. DATE SIGNED <u>Dec. 19, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/19/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Charles Mo.</u>
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24. FUNERAL DIRECTOR <u>Arthur C Baue Funeral Home</u> ADDRESS <u>St Charles Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 19 61</u>	26. REGISTRAR'S SIGNATURE <u>Marcelle Wilson</u>
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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 by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John C. Smith

Licensed Embalmer No. 5145

P. O. Address St. Charles

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.