

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018655

STATE FILE NUMBER

FILED JUN 15 1959

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 306

S. 300
1-57

| | | | | | |
|---|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pettis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sedalia</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Sedalia</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>311 East 25th</u> | | Length of stay in lb <u>Life</u> | d. STREET ADDRESS (If outside, give location) <u>311 East 25th</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Violet Stetzenbach</u> | | | 4. DATE OF DEATH Month Day Year <u>June 12 1959</u> | | |
| 5. SEX <u>Female</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>June 8 1907</u> | | 9. AGE (In years) last birthday <u>52</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 11. BIRTHPLACE (City and state or country) <u>Sedalia Mo</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13a. FATHER'S NAME <u>George H. Beeler</u> | | 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE <u>Francis C. Stetzenbach</u> | |
| 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 Address <u>311 E 25th</u> <u>Sedalia</u> | | |
| 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>Uremic Septicemia</u> DUE TO (b) <u>Acute Parenchymatous Nephritis unknown</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ a.m. _____ p.m. _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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 <u>6-9-59</u> to <u>6-12-59</u> and last saw her alive on <u>6-9-59</u> Death occurred at <u>6-12-59</u> <u>7:30</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>A.R. Maddox M.D.</u> | | | 22b. ADDRESS <u>Sedalia Mo</u> | | 22c. DATE SIGNED <u>6-12-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>6-15-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill</u> | | 23d. LOCATION (City, town, or county) (State) <u>Pettis Co. Mo</u> |
| 24. FUNERAL DIRECTOR <u>McLaughlin Bros</u> | | ADDRESS <u>Sedalia</u> | | 25. DATE RECD. BY LOCAL REG. <u>6/13/1959</u> | 26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *K.P.M. Crary*
Licensed Embalmer No. *3153*
P. O. Address *Sedalia 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.