

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-048968

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 424

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 24 1963

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sedalia		Length of stay in 1b 6 weeks	c. CITY OR TOWN Mora, Route 1 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bothwell Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.F.D. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JOHN Middle AUGUST Last STUHNER			4. DATE OF DEATH Month December Day 14 , Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/1/85
9. AGE (last birthday) 78		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Agriculture	11. BIRTHPLACE (City and state or country) Mora, Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Jacob Stuhner	
13b. MOTHER'S MAIDEN NAME Elizabeth Heineman		14. NAME OF HUSBAND OR WIFE Leota Simon Stuhner, dec'd.	
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. 497-42-6120	17. INFORMANT Mrs. William Hoff, Buffalo, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH 10 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility			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 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 _____ s.m. _____ p.m. _____	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 2/1/63 to 12/14/63 and last saw her alive on 12/14/63 . Death occurred at 3:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) F. J. Holden M.D.		22b. ADDRESS 1116 W 3rd Sedalia Mo	22c. DATE SIGNED 12/14/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/17/63	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or County) (State) Sedalia, Missouri
24. GENERAL DIRECTOR Francis Shelby Pitt	ADDRESS Sedalia, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 17, 1963	26. REGISTRAR'S SIGNATURE n. Anderson

VS 300 Rev. 4/59

1 **0808**

2 **0800**

3 **1**

4 **0**

5 **2**

6

7 **0**

8 **0**

9 **434.1**

10

11

12 **1-2**

13 **10**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1-1-1980

1-1-1980

1080
1080

1484

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 R. E. Baker

Licensed Embalmer No. 2419

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.