DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40658

Registration District No. 757 Primary Registration District No. 3036 Registrar's No. 170

1. PLACE OF DEATH:

(a) County: St. Charles

(b) City or town: St. Charles (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: St. Charles

(c) City or town: Portage De Sioux, Mo (If outside city or town limits, write "RURAL")

(d) Street No.: ✓ (If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME: Casper Stenger 352

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Theresa Ost

6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: March (Month) 30 (Day) 1864 (Year)

8. AGE: Years 74 Months 7 Days 15 If less than one day hr. min.

9. Birthplace: O'Fallon (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business: ✓

FATHER

12. Name: John Stenger

13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Mary (Hoppelman) Stenger

15. Birthplace: Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Leo Stenger

(b) Address: St. Charles, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 18 1939 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Francis Cem. Portage De Sioux

18. (a) Signature of funeral director: H. C. Ballmeyer & Sons

(b) Address: 800 N. Second, St. Charles, Mo

19. (a) 11/17/39 (Date received local registrar) (b) Clarence H. Heisler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15 year 1939 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 14-39, 19..., to Nov 15, 1939; that I last saw him alive on Nov 15, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemiplegia	1 day
Due to: Hypertension	
Uremia	
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Vincent A. Schneider (M. D. or other)

Address: St. Charles, Mo Date signed 11/17/39

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40658
Do not use this space.

1. PLACE OF DEATH
(a) County St Charles — Registration District No. 757
(b) Township — Primary Registration District No. 3036 — Registered No.
(c) City St Charles (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Casper Stenger
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	7	15	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 15 1939

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw him alive on 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemiplegia	
Cerebral Hemorrhage	Nov 14-39

Other contributory causes of importance:
Hypertension & Arteriosclerosis

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Vincent A Schneider M. D.
(Address) St Charles Mo

SUPPLEMENTAL