

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11612

State File No. _____

Registration District No. 142

Primary Registration District No. 5698

Registrar's No. _____

1. PLACE OF DEATH:

(a) County McDonald
(b) City or town Rural Buffalo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 7
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 yrs years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County McDonald
(c) City or town Goodman Mo RFD 1
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Dave Stucke 370

3. (b) If veteran, name war. ✓ 3. (c) Social Security No. ✓

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 16 1896
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Switzerland (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name John Stucke

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

14. Maiden name Anna Langert

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

16. (a) Informant Oscar Cain

(b) Address Goodman Mo

17. (a) Burial (b) Date thereof Mar 20 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation First Cemetery

18. (a) Signature of funeral director Chas. W. Williams

(b) Address Goodman Mo
19. (a) 4-19-40 (b) Chas. W. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19
year 1940 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Died of Heart Attack Duration _____

Due to had no doctor

Due to Signed Williams 10

Other conditions fatal 1899

(Include pregnancy within 6 months of death)

Major findings: Dist No 142

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? 414
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) ✓

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 23 1940

RECEIVED

District Health Officer No. 6,
District File Number 440-1138
Date Filed APR 1 5 1940

JUL 1 1957

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 with the above constitutes grounds for revocation of license.)

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