

12241

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 8 1940

775 Primary Registration District No.

1.1.1.1.A Registrar's No.

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

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.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(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)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community _____
years, months or days) 3 2 5

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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

Geo. B. Stegmaier

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex ✓

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife 1

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

7. Birth date of deceased Aug 20th 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>6</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation Baker

11. Industry or business _____

12. Name Hutlob Stegmaier

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

14. Maiden name Mary Rudemayr

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

16. (a) Indemnity own signature Hildegard Stegmaier

(b) Address Flat River mo

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

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director Goodwell Bus

(b) Address Flat River mo

19. (a) ✓ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23
year 1940 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from Feb. 21, 1940, to Feb. 23, 1940;
that I last saw him alive on Feb. 23, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Shock resulting from automobile injury, contusions of face, head & body with multiple skin lacerations; compound fracture of tibia, plus left side injury to chest and sternum & costal cage
Due to _____

Duration 1 1/2 days

Due to _____

Other conditions Excessive weight; diabetes
(Include pregnancy within 3 months of death)

Major findings: Of operations no operation

Of autopsy no autopsy

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

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

(b) Date of occurrence 2-23-40

(c) Where did injury occur? 4 miles north of Bonne Terre, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In public place: on highway 61, 4 miles north of Bonne Terre.

While at work? _____ (e) Means of injury Automobile

23. Signature D. E. Smith (M. D. or other) MD

Address Bonne Terre, Mo. Date signed 2-26-40

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

ALM
9/10

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12244

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 778

Primary Registration District No. 6020A

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Boone Terre
(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)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Geo B Stegmaier

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one year _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1940 hour 9 minute 40 A.M.

21. I hereby certify that I attended the deceased from 2-21 1940 to 2-23 1940 that last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Shock resulting from automobile injury Duration _____

Due to _____

Due to Non-collision

Other conditions _____ (Include pregnancy within 3 months of death) J. I. D. W. 2/23

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? Non-collision (City or town) (County) (State)

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

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

23. Signature J. E. Smith (M. D. or other) _____

Address Boone Terre mo State signed _____

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12244

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 775

Primary Registration District No. 6020 A

Registrar's No.

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

1. PLACE OF BIRTH:

(a) County: St. Francois
(b) City or town: Booneville
(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)

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

3. (a) PRINT FULL NAME

Geo. B. Stegmaier

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: Married

6. (b) Name of husband or wife: Unable to obtain wife's name

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

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

8. AGE: Years Months Days If less than one day
60 6 3 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) June 19, 1940 (Date received local registrar) (b) N. W. Hawkins (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 23 year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from 2-21- 1940 to 2-23 1940 that I last saw him alive on 9 40 am 19.....

and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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?

While at work? (Specify type of place) (r) Means of injury.....

23. Signature: D. E. Smith (M. D. or other)

Address: Booneville Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY