

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18353**
Registrar's No. _____

Registration District No. **293**

Primary Registration District No. **5416**

1. PLACE OF DEATH:

(a) County **FRANKLIN**
(b) City or town **RURAL - CALVEY TWP.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **24 YRS - 6 MON - 20 DAY**
years, months or days

8. (a) PRINT FULL NAME **JOHN - STUEHLFELDER**

3. (b) If veteran, name war **V** 8. (c) Social Security No. **V**

4. Sex **MALE** 5. Color or race **WIFE**
6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **V** 6. (c) Age of husband or wife If alive **V** years

7. Birth date of deceased **OCT. 15 1865**
(Month) (Day) (Year)

8. AGE: Years **74** Months **6** Days **20** If less than one day _____ hr. _____ min.

9. Birthplace **CATAWISSA - MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **FARMER**

11. Industry or business **FARMING**

12. Name **Joseph Stuehlfelder**

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

14. Maiden name **Mitchell**

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

16. (a) Informant **Gene Brodie**
(b) Address **Radcliff, Mo. R. D.**

17. (a) **CATAWISSA - MO.** (b) Date thereof **5-8-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MITCHELL CEMETERY**

18. (a) Signature of funeral director **elcheve**
(b) Address **Catawissa, mo**
19. (a) **5-9-40** (b) **Mary O. Gross**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** - (b) County **FRANKLIN**
(c) City or town **RURAL**
(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 **MAY** - day **6**
year **1940** - hour **3** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Apr. 28-40**
to **May 6, 1940**
that I last saw him alive on **Apr. 28, 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
of Prostate Gland
Due to **V** Duration **2 YEARS**

Due to **V**
Other conditions **V**
(Include pregnancy within 3 months of death)

Major findings: **V**
Of operations **V**

Of autopsy **V**
Underlines 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) **V**
(b) Date of occurrence **V**

(c) Where did injury occur? **V**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **V**

While at work? **V** (Specify type of place)
(a) Means of injury **V**

23. Signature **Stacy E. Roithner** (M. D. or other **M.D.**)
Address **Pacific Mo** Date signed **5-7-40**

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

MOTHER FATHER

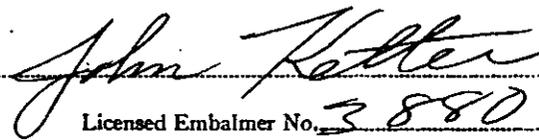
STATEMENT BY LICENSED EMBALMER

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. 3880

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.