

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

State File No. 35020

Registration District No. 135 Primary Registration District No. 3010

Registrar's No. 93

1. PLACE OF DEATH:
(a) County Carroll County
(b) City or town Carrollton Mo.
(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 3
In this community 39 years
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Lafayette
(c) City or town Higginsville 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 Haddon Charles Stosberg
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 11
year 1940 hour 8 minute 30P M.

4. Sex male 5. Color or race white 6. (a) Single, widowed, (married) divorced _____
6. (b) Name of husband or wife Mrs. Rose Stosberg 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 28, 1892
(Month) (Day) (Year)

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.

8. AGE: Years Months Days If less than one day
48 7 14 _____ hr. _____ min.

Immediate cause of death _____
Due to _____
Due to _____

9. Birthplace Concordia Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

MOTHER FATHER { 12. Name Samuel J. Stosberg
13. Birthplace Concordia Mo. (City, town, or county) (State or foreign country)
14. Maiden name Carie Herd
15. Birthplace Concordia Mo. (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Haddon Stosberg
(b) Address Higginsville Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation Higginsville Mo.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence Oct 11-1940

18. (a) Signature of funeral director G. B. Hader
(b) Address Higginsville Mo.
19. (a) 10-14-40 (Date received local registrar) (b) Arthur Harker (Registrar's signature)

(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?
At foot ball game at Carrollton Mo
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Ed Dickerson (M.D. or other) _____
Address Bagdad Mo Date signed _____

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

17
3
1

FS

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed: 11-14-40

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.....

.....
Forest Riekhof, Registered Apprentice No.....
working under my personal supervision.

Signed.....
Forest Riekhof

Licensed Embalmer No. 3637

P. O. Address Higginsville 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 this body is not embalmed, fact should be so stated above.