

Registration District No. **486**

Primary Registration District No. **0650**

Registrar's No. **32**

1. PLACE OF DEATH:

(a) County Lincoln - Burr Oak Township
(b) City or town Five miles west of Foley, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
at residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Twelve years
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lincoln
(c) City or town Rural - five miles west Foley
(If outside city or town limits, write "RURAL")
(d) Street No. Burr Oak Township
(If rural, give location) 0
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Benjamin Franklin Stirlinginger

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Mary Susan Watts (deceased) 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Feb 25 - 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Foley, R.F.D. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation farming

11. Industry or business

12. Name Gebhart Stirlinginger 6
18. Birthplace Germany (State or foreign country)
14. Maiden name Martha Jane Jewell
15. Birthplace Lincoln County Mo. (State or foreign country)

16. (a) Informant Mr. Jim Stirlinginger
(b) Address Elsberry, Mo.
17. (a) Corinth-Foley (b) Date thereof 11/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Charles Ricks
(b) Address Celina, Mo.
19. (a) Nov-14 (b) Etta Powell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Nov. day 13
year 1940 hour 7 minute 15 p.m.
21. I hereby certify that I attended the deceased from Nov. 10
_____ 1940 to Nov. 13 1940
that I last saw him alive on Nov. 13 1940
and that death occurred on the date and hour stated above

Immediate cause of death Acute nephritis (9)
Duration _____

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

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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?
880 (Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature H. C. Finley (M. D. or other) M.D.
Address Elsberry Mo Date signed 11-14-40

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

FILED DEC 17 1940

120

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 *Charles Hicks*

Licensed Embalmer No. 4012

P. O. Address Winfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 39110
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 486

Primary Registration District No. 2680

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

1. PLACE OF DEATH:
(a) County Lancaster
(b) City or town Burr Oak
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Bessy Franklin Shirmelinger
(b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 71 Months 8 Days 19 If less than one day _____ hr _____ 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 11 day 13 year 1940 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis 4 days
Due to chronic nephritis 10 yrs
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 171

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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTAL

S-39110 1940