

FILED JAN 8 1945

Registration District No. 70

Primary Registration District No. 4124

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Clark  
(b) City or town Kahoka  
(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 1  
(Specify whether

In this community  
years, months or days)

3. (a) PRINT FULL NAME Louis Stutz

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

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alice Jane Hanslow 6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased November 23 - 1853  
(Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 21 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ludwig Stutz 13. Birthplace Germany  
14. Maiden name Marie Beela Schilling 15. Birthplace Germany

16. (a) Informant Mrs Louis Stutz  
(b) Address Kahoka Mo.

17. (a) Burial (b) Date thereof 8-16-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kahoka Cemetery

18. (a) Signature of funeral director Fred Gerke

(b) Address Kahoka Mo.

19. (a) 12-29-44 (b) Permy Boston  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clark 23  
(c) City or town Kahoka  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14th  
year 1944 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Aug 1 1944 to Aug 14 1944  
that I last saw him alive on 8/14-44 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis  
Duration \_\_\_\_\_

Due to Arteriosclerosis  
Due to Hereditary

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94a  
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?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature J. R. Bridger (M. D. or other) \_\_\_\_\_  
Address Kahoka Mo. Date signed 8/19-44

1213

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

STAMP

RECEIVED

District Health Officer No. 10

District File Number 1-45-29

Date Filed JAN 5 1945

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 J. J. Kares

Licensed Embalmer No. 1023

P. O. Address Kokomo, Ind.

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.