

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26372
881
Registrar's No. 881

Primary Registration District No. 1000

FILED AUG 12 1946

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp # 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14yr 9mo 19da
(Specify whether in this community 14yr 9mo 19da years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan 11

(c) City or town Rock Port 1
(If outside city or town limits, write "RURAL")

(d) Street No. 7
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Charles Stickerod

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Lola Stickerod

6. (c) Age of husband or wife if alive about 45 years

7. Birth date of deceased Jan 11 1890
(Month) (Day) (Year)

8. AGE: Years 56 Months 6 Days 25
If less than one day hr. _____ min. _____

9. Birthplace Rock Port MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Carroll Stickerod

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

14. Maiden name Anna Elizabeth Stickerod

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

16. (a) Informant Ms Lola Stickerod

(b) Address Road Rock Port Mo

17. (a) burial (b) Date thereof 8/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rockport, Mo

18. (a) Signature of funeral director Heater Bethe & Bauern

(b) Address St. Joseph Mo

19. (a) AUG. 7, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
year 1946 hour 11:30 minute 0 M.

21. I hereby certify that I attended the deceased from June 1946, to Aug 6 1946
that I last saw him alive on Aug 5 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Submersion J. B.
Duration years

Due to _____

Due to _____

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

Major findings: Of operations 130

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 [Signature] MD (M. D. or other) 0
Address State Hosp. #2, Date signed 8/6/46

MAY 13 1948

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 Eugene Wood
Licensed Embalmer No. 3804
P. O. Address 319 South St. Joseph, 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.