

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 9 1947
128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
2000

State File No. **17168**
Registrar's No. **450**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County **GREENE**
Springfield
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Burge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 year** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Rudolph Stahl Sr.**
3. (b) If veteran, name war **None**
3. (c) Social Security No. _____

4. Sex **male** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **Widower**
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive **8, 1876** years (Month) (Day) (Year)

8. AGE: Years **71** Months **3** Days **19** If less than one day hr. min.

9. Birthplace **Sullivan Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Carpenter**
11. Industry or business **Carpentering**

12. Name **G. A. Stahl**
13. Birthplace **New York N. Y.** (City, town, or county) (State or foreign country)

14. Maiden name **Anna Tilley**
15. Birthplace **Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. E. W. Lamon**
(b) Address **Springfield Mo.**
17. (a) **Burial** (b) Date thereof **5-29-1947** (Month) (Day) (Year)
(c) Place: burial or cremation **Green Lawn Cem.**

18. (a) Signature of funeral director **W. Handley & Co.**
(b) Address **Springfield Mo.**

19. (a) **5-27-47** (b) **W. Handley W.D.** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield** (If outside city or town limits, write "RURAL")
(d) Street No. **823 W. Division St.,** (If rural, give location).
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **5** day **27** year **1947** hour **6** minute **15 A.M.**
21. I hereby certify that I attended the deceased from **March 28, 1947** to **May 26, 1947**; that I last saw him alive on **May 26, 1947**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hodgkins Disease** Duration **6 mo.**

Due to _____
Due to _____
Other conditions **Coronary artery disease** 3-4 yr (Include pregnancy within 3 months of death)

Major findings: **mass**
Of operations **Large tumor involving entire ascending colon and metastasis regional lymph glands.**

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) Means of injury _____
23. Signature **[Signature]** (M. D. _____)
Address **450 1/2 E. Commercial** Date signed **5-27-47**

spld, mo.

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

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.....

Max Rhodes

Licensed Embalmer No.

4071

P. O. Address.....

Springfield

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.