

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 5 1951

State File No. **32594**

BIRTH NO. _____ REG. DIST. NO. 34 PRIMARY REG. DIST. NO. 5117 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural Cedar</u>	c. LENGTH OF STAY (in this place) <u>2 yr</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Cedar</u> <u>0100</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hartsburg R.F.D.</u>		d. STREET ADDRESS (If rural, give location) <u>Hartsburg R.F.D.</u>	

3. NAME OF DECEASED (Type or Print)
a. (First) Mary b. (Middle) Stutz c. (Last) _____
4. DATE OF DEATH (Month) (Day) (Year)
Oct 23 1951

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Nov. 21 1862 9. AGE (in years, last birthday) 88 11 2 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country)
Wisconsin 12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
Joseph Thiessen 13b. MOTHER'S MAIDEN NAME
Mary Bartlett 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME
Peter B. Stutz ADDRESS
Hartsburg Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident INTERVAL BETWEEN ONSET AND DEATH
few minutes
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
331X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan, 1950, to Oct, 1951, that I last saw the deceased alive on Sept 20, 1951, and the death occurred at 7am m., from the causes and on the date stated above.

23a. SIGNATURE
LeRoy Miller M.D. (Degree or title) 23b. ADDRESS
Ashland Mo. 23c. DATE SIGNED
23 Oct 51

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE
Burial 10-26 1951 24c. NAME OF CEMETERY OR CREMATORY
Minden Cemt. 24d. LOCATION (City, town, or county) (State)
Minden Iowa

DATE REC'D BY LOCAL REG. Oct 23/51 REGISTRAR'S SIGNATURE
Mrs Mildred Burnett 25. FUNERAL DIRECTOR'S SIGNATURE
Wm C. Burnett ADDRESS
Ashland Mo

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

RECEIVED NOV 3 - 1951

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed NOV 3 - 1951 _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Wm. L. Burnett* _____

Licensed Embalmer No. *3564* _____

P. O. Address *Ashtland 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.