FILED JAN 11 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41148

BIRTH NO. _____ REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 5391 Registrar's No. 1

1. PLACE OF DEATH
a. COUNTY: Dent
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twp 33 TEXAS
c. LENGTH OF STAY (In this place): 7 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Iowa
b. COUNTY: DesMoine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burlington
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Sylvester
c. (Last): Stutsman

4. DATE OF DEATH (Month) (Day) (Year): Dec. 31, 1951

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan 5, 1862
9. AGE (In years last birthday): 89 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior Decorator
10b. KIND OF BUSINESS OR INDUSTRY: Decorator
11. BIRTHPLACE (State or foreign country): South Bend Ind.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Henry Stutsman
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Martha Jane Stutsman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Leona Drown **ADDRESS**: Rt. 1 Salem MO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

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: None
19b. MAJOR FINDINGS OF OPERATION: 334X
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
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 _____, 19__, to _____, 19__, that I last saw the deceased alive on* Dec 10, 1951, *and that death occurred at* 5:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Luther Randall MD
23b. ADDRESS: Lukens
23c. DATE SIGNED: 1-4-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 4, 52
24c. NAME OF CEMETERY OR CREMATORY: Berry Cemetery
24d. LOCATION (City, town, or county) (State): Dent County Mo.

DATE REC'D BY LOCAL REG.: 1-4-52
REGISTRAR'S SIGNATURE: M. M. Hart, MD Lyk
25. FUNERAL DIRECTOR'S SIGNATURE: Hobson & Grantham **ADDRESS**: Salem, Mo.

83-1 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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~~ .....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Marshall C. Blackwell

Licensed Embalmer No. 4713

P. O. Address Salem, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.