

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28969

State File No.

FILED SEP 3- 1952

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 271

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sedalia	
c. LENGTH OF STAY (In this place) 12 days		d. STREET ADDRESS (If rural, give location) 1223 S. Stewart	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bothwell Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Martin c. (Last) Stober			4. DATE OF DEATH (Month) (Day) (Year) Aug 25, 1952		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 27, 1870	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 4 Days 28	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frt. handler	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Harrisburg, Penn.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME J. J. Stober	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Cora B. Stober
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 	17. INFORMANT'S SIGNATURE OR NAME Cora Stober, Sedalia, Mo. ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Embolism.		5 min.
	ANTECEDENT CAUSES DUE TO (b) Hypertensive Heart Disease.		2 yrs.
	DUE TO (c) Arterio-Sclerosis- Advanced.		2 years.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uremia.		2 weeks.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Medical treatment only.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None.	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from over 5 yrs., 19 to Aug. 25th, 1952, that I last saw the deceased alive on Aug. 25th, 1952, and that death occurred at 7:15 pm., from the causes and on the date stated above.

23a. SIGNATURE Jno. B. Carlisle, M.D. (Degree or title)	23b. ADDRESS Sedalia, Missouri.	23c. DATE SIGNED Aug. 26th, 52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug 27, 1952	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) Sedalia, Mo.
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DATE REC'D BY LOCAL REG. 8/27/52	REGISTRAR'S SIGNATURE [Signature]	GENERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Sedalia, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

304

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 P. E. Baker

Licensed Embalmer No. 2419

P. O. Address Sedalia 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.