

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15002

State File No. _____
Registrar's No. 147

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 304B

644
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

| | | | |
|--|-----------------------------------|--|------|
| 1. PLACE OF DEATH a. COUNTY Marion | | 2. USUAL RESIDENCE (Where deceased lived) If institution: residence before admission) a. STATE Illinois b. COUNTY Pike | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal | c. LENGTH OF STAY (In this place) | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hull | 8120 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hospital | | d. STREET ADDRESS R#1 | |

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|--|---------------------------|---|-------------------------------|---|------------------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) Marie Stolte | | | 4. DATE OF DEATH 4/9/53 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 8/18/1877 | 9. AGE (In years last birthday) 75 | 10. IF UNDER 1 YEAR Months 7 | 11. IF UNDER 24 HRS. Hours Min. |
| 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 (City and State or Foreign Country) Bohemia, Prague | | 12. CITIZEN OF WHAT COUNTRY? USA |

| | | | | |
|--------------------------------------|---|--|--------------------------------------|--|
| 13a. FATHER'S NAME John Kratochil | 13b. MOTHER'S MAIDEN NAME Mary Unknown | | 14. NAME OF HUSBAND OR WIFE Frank | |
|--------------------------------------|---|--|--------------------------------------|--|

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|--|-------------------------|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Frank Stolte R#1, Hull, Illinois | | ADDRESS |
|--|-------------------------|--|--|---------|

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|--|--|---|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) congestive heart failure | | cerebrael vascular accident | | | 2 days |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | DUE TO (b) artieo sclerotic cardio vascular disease | | | 5 days |
| DUE TO (c) | | disease | | | 2 yrs |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|------------------------|--|--|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 4221 | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|--|---|--|

| | | |
|--|--|---|
| 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) |
|--|--|---|

| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from 4/5/53, 19__, to 4/9/53, 19__, that I last saw the deceased alive on 4/9/53, 19__, and that death occurred at 1:55P m., from the causes and on the date stated above.

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|---|-------------------|--|-----------------------------|
| 23a. SIGNATURE F. E. Gultman M.D. M.D.F.A.C.S. | (Degree or title) | 23b. ADDRESS 115 N. 5th St., Hannibal, Mo | 23c. DATE SIGNED 4/10/53 |
|---|-------------------|--|-----------------------------|

| | | | |
|---|----------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 4/11/53 | 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | 24d. LOCATION (City, town, or county) (State) Hannibal Marion Mo. |
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| DATE REC'D BY LOCAL REG. 4/13/53 | REGISTRAR'S SIGNATURE H. C. Fisher | 25. FUNERAL DIRECTOR'S SIGNATURE H. M. O'Donnell | ADDRESS Hannibal Mo |
|-------------------------------------|---------------------------------------|---|------------------------|

RECEIVED

APR 22 1959

MARIEN CO. HEALTH DEPT.

DATE FILED

APR 22 1959

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 *A. M. O'Hara*

Licensed Embalmer No. 3889

P. O. Address *St. Louis, 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.