

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36916**

300  
48

FILED NOV 9 - 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3058** Registrar's No. **229**

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST. CHARLES MO</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MO.</b> b. COUNTY <b>ST CHARLES</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST CHARLES</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. CHARLES 0920</b>                                      |  |
| c. LENGTH OF STAY (in this place) <b>14 days</b>   |  | d. STREET ADDRESS (If rural, give location) <b>Rt #3 - ST CHARLES, MO</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST JOSEPH HOSPITAL</b>                              |  |   |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 3. NAME OF DECEASED<br>a. (First) <b>BERNARD</b><br>(Type or Print)  |  | b. (Middle) <b>STUKEMEIER</b>                   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>OCT. 29. 1953</b>       |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>CAUCASIAN</b>               |  | 7. MARRIED NEVER MARRIED, WIDOWED <b>DIVORCED</b> (Specify)         |  |
| 8. DATE OF BIRTH <b>12-25-1871</b>   |  | 9. AGE (In years last birthday) <b>82</b>       |  | IF UNDER 1 YEAR Days <b>10</b> Hours <b>4</b> IF UNDER 12 HRS. Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILL WORKER</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Geneta</b> |  | 11. BIRTHPLACE (State or foreign country) <b>ST LOUIS, MO.</b>      |  |
|  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                            |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME <b>CHRISTIAN STUKEMEIER</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>MARY TURGENSMEIER</b> |  | 14. NAME OF HUSBAND OR WIFE _____   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b> |  | 16. SOCIAL SECURITY NO. _____                      |  | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS<br><b>Walter Stuckemeyer, 1409 N. 32nd St. Charles, Mo.</b> |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Heart Failure</b>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>                                    |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>gen. arterio sclerosis</b>               |  | <b>5 yrs.</b>   |  |
|   |  | DUE TO (c) <b>4501</b>  |  |   |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>arterio sclerosis gangrene 1 hand</b> |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Both feet &amp; legs</b>   |  | 20. AUTOPSY?<br>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) (Min.) |  | 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 **4-5-1953**, to **10-29-1953**, that I last saw the deceased alive on **10-29-1953**, and that death occurred at **7 p. m.**, from the causes and on the date stated above.

|  |  |                                       |  |   |  |
|--|--|---------------------------------------|--|---|--|
| 23a. SIGNATURE (Degree or title)<br><b>R. R. Riddle M.D.</b> |  | 23b. ADDRESS<br><b>St Charles, MO</b> |  | 23c. DATE SIGNED<br><b>Oct 31 1953</b>                                  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24b. DATE<br><b>11-2-53</b>           |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PETERS CATH. CEM.</b>      |  |
|  |  |                                       |  | 24d. LOCATION (City, town, or county) (State)<br><b>ST. CHARLES MO.</b> |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| DATE REC'D BY LOCAL REG.<br><b>Oct 30 1953</b> |  | REGISTRAR'S SIGNATURE<br><b>Francis Hamilton</b> |  | FUNERAL DIRECTOR'S SIGNATURE<br><b>Prinster-Hughes Funeral Home Inc.</b> |  |
|  |  |  |  | ADDRESS<br><b>St. Charles Mo.</b>  |  |

(Licensed Embalmer's Statement on Reverse Side) **C. L. Prinster.**

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

NOV 16 1923

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*John S. Pennek*  
Licensed Embalmer No. *4194*  
P. O. Address *St. Louis, Mo*

Signed.....  
Student Embalmer

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.