

FILED AUG 9 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23524

BIRTH NO. 89734-53 REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 73

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before institution) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Lexington Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Mayview Mo 63540</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lexington Memorial Hosp</u>		d. STREET ADDRESS <u>R R # 1 south of town</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Louis</u> b. (Middle) <u>Robert</u> c. (Last) <u>Stuedle</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <u>Nov 24 1953</u>		9. AGE (In years last birthday) <u>7</u>		10. MONTHS <u>7</u> DAYS <u>16</u> HOURS <u>16</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Liberty Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Louis R. Stuedle</u>		13b. MOTHER'S MAIDEN NAME <u>Patricia R. Ivy</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	

17. INFORMANT'S SIGNATURE OR NAME <u>Louis R. Stuedle, Mayview, Missouri</u>		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Dehydration, Electrolyte imbalance + infection</u> *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Dehydration, Electrolyte imbalance + infection</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Severe diarrhea</u> DUE TO (c) <u>Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>No Surgery</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>293X</u>	
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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?	
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22. I hereby certify that I attended the deceased from July 15, 1954 to July 16, 1954, that I last saw the deceased alive on July 15, 1954, and that death occurred at 8A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>W. H. Martin MD</u>		23b. ADDRESS <u>Odesse Mo</u>		23c. DATE SIGNED <u>7-25-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 18 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Marvin Chapel</u>	
24d. LOCATION (City, town, or county) (State) <u>Mayview Mo Missouri</u>		DATE REC'D BY LOCAL REG. <u>5-4-54</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Galbraith</u>	
FURNERAL DIRECTOR'S SIGNATURE <u>James F. Tempel</u>		ADDRESS <u>Lexington, Missouri</u>			

(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 *Geo. McKean*

Licensed Embalmer No. 2983

P. O. Address *Leung's Museum*

**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.