

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010850
STATE FILE NUMBER

FILED MAR 17 1958

Registration District No. 267 Primary Registration District No. 3048 Registrar's No. SL

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>NODAWAY</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARYVILLE</u>		a. STATE <u>MISSOURI</u> b. COUNTY <u>NODAWAY</u>		c. CITY OR TOWN <u>CONCEPTION Jct.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS Hosp</u>		Length of stay in 1b <u>2 DAYS</u>		d. STREET ADDRESS <u>EAST PART OF TOWN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>JOHN</u>		Middle <u>MICHAEL</u>		Last <u>STURM</u>		Month <u>MARCH</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1914</u>	9. AGE (In years last birthday) <u>43</u>	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FILLING STATION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OIL & GASOLINE</u>		11. BIRTHPLACE (City and state or country) <u>CONCEPTION, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN F. STURM</u>				14. MOTHER'S MAIDEN NAME <u>ELEANOR O'CONNOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>487-14-4247</u>		17. INFORMANT <u>MRS. MAXINE STURM</u> Address <u>CONCEPTION Jct MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage -</u> <u>Chronic Arteriosclerosis - Recurrent -</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Arteriosclerosis - Recurrent -</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs - 1 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>331X</u>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>1-31-57</u> to <u>3/5/58</u> and last saw her alive on <u>3/5/58</u> . Death occurred at <u>6:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Shirley M. Do</u> (Degree or title)				22b. ADDRESS <u>Maryville, Mo</u>		22c. DATE SIGNED <u>3/5/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MARCH 8-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. COLUMBA</u>		23d. LOCATION (City, town, or county) (State) <u>CONCEPTION, MO.</u>	
24. FUNERAL DIRECTOR <u>JOHNSON FUNERAL HOME</u> ADDRESS <u>CONCEPTION Jct., Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>3-15-58</u>		26. REGISTRAR'S SIGNATURE <u>Beno Volt</u>	

(Licensed Embalmer's Statement on Reverse Side)

health, Welfare public service
 300 1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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
Signature of Student Embalmer

Signed *Lois E. Johnson*

Licensed Embalmer No. *494*

P. O. Address *Stanberry*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.