

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010971  
STATE FILE NUMBER

FILED MAR 24 1958

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 162

300  
-57

COLESE FUNERAL HOME

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISEASES IN PART I MUST BE CAUSALLY RELATED.

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jtterville 0270</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Length of stay in lb <u>7 days</u>	d. STREET ADDRESS (If outside, give location) <u>No town address</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>STUMP</u> Last <u>STUMP</u>			4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1958</u>		
5. SEX <u>Male 0</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1885</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	11. BIRTHPLACE (City and state or country) <u>Highland, Illinois /</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Charles Stumpf</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Steiner</u>		14. NAME OF HUSBAND OR WIFE <u>Naomi Olgartia Stumpf</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>  </u>	17. INFORMANT Address <u>Everett Stumpf, 1000 W. 10th, Sedalia, 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>Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Gastric ulcer</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>5400</u>					
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>2</u>			
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>					
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>3-8-58</u> to <u>3-17-58</u> and last saw <u>him</u> alive on <u>3-17-58</u> Death occurred at <u>8:50 am.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. Boyer M.D.</u> (Degree or title)			22b. ADDRESS <u>Sedalia Mo</u>		22c. DATE SIGNED <u>3-17-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/19/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>	
24. FUNERAL DIRECTOR <u>D. W. Heckart, 903 S. Ohio, Sedalia</u>		25. DATE RECD. BY LOCAL REG. <u>3-18-1958</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>		

MISSOURI DEPARTMENT OF HEALTH

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 *Russell P. Maag* .....

Licensed Embalmer No. *4804* .....

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