

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035720  
STATE FILE NUMBER

FILED NOV 10 1958

Registration District No. 52 Primary Registration District No. 2010 Registrar's No. 511

300  
1-57

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1. PLACE OF DEATH a. COUNTY <u>CAPE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAPE GIRARDEAU</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CHAFFEE</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>CAPE OSTEOPATHIC HOSP</u>		Length of stay in 1b <u>3 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>301 HELEN AVE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH ARON STATLER</u>			4. DATE OF DEATH Month Day Year <u>OCT. 23, 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>MARCH 8, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days <u>7 15</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARTON MAKER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SPORTS SPECIALTY SHOE CO</u>		11. BIRTHPLACE (City and state or country) <u>SEDGEWICKVILLE, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>DANIEL LOGAN STATLER</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH HANNAHS</u>		14. NAME OF HUSBAND OR WIFE <u>CARRIE ELLEN STATLER</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>489-26-5459</u>		17. INFORMANT Address <u>MRS. JOSEPH A. STATLER - CHAFFEE, 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>Acute Pulmonary Edema.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
- Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Subarachnoid Hemorrhage</u>		<u>3 days</u>
	DUE TO (c) <u>Arteriosclerosis</u>		<u>330X 10 yrs.</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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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>10-20-58</u> to <u>10-23-58</u> and last saw <sup>her</sup> him alive on <u>10-23-58</u> Death occurred at <u>11:35 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. H. Helmeyer, D.O. &amp;</u>			22b. ADDRESS <u>Chaffee, Missouri</u>		22c. DATE SIGNED <u>10/25/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 26, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEDGEWICKVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>SEDGEWICKVILLE, MO.</u>
24. FUNERAL DIRECTOR <u>BISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT. 30, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Homer Cooper</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 11 1958

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 *Jack T. Burnett* .....  
Licensed Embalmer No. *4473* .....  
P. O. Address *Chaffee, 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.