

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013929

STATE FILE NUMBER

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 36

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Lafayette</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Lexington</u>                   |  | c. CITY OR TOWN <u>Higginsville, Mo.</u>   |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>415 Fair Ground Ave.</u>   |  |
| Length of stay in lb <u>5 days</u>  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|  |                                  |  |  |  |   |
|--|----------------------------------|--|--|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Otto</u> Middle <u>John Henry</u> Last <u>Stuerke</u>                  |                                  |  | 4. DATE OF DEATH<br>Month <u>March</u> Day <u>19</u> Year <u>1959</u>    |  |   |
| 5. SEX<br><u>male</u>  | 6. COLOR OR RACE<br><u>white</u> | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan. 11, 1883</u>                                 | 9. AGE (In years last birthday)<br><u>76</u>           | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u>          |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm Owner</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Sweetsprings, Mo.</u>   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>          |   |
| 13a. FATHER'S NAME<br><u>Brown Henry Stuerke</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Anna Steffans</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Mrs Maud Stuerke</u> |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>499-32-2229</u>  | 17. INFORMANT<br>Address <u>Son - Melvin Stuerke - Higginsville, Mo.</u> |  |   |

|   |                               |   |
|---|-------------------------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>                        |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>APV disease</u> | <u>vis</u>  |
|   | DUE TO (c) <u>422IF</u>       |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Fractured ribs + pleural effusion due to fall</u> |                               | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <u>8:15</u> Month <u>3</u> Day <u>19</u> Year <u>1959</u><br>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<br><u>Higginsville Mo.</u> | COUNTY | STATE |
| 21. I attended the deceased from <u>1950</u> to <u>3/19/59</u> and last saw him alive on <u>3/19/59</u><br>Death occurred at <u>8:15</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |        |       |
| 22a. SIGNATURE (Degree or title)<br><u>Robert B. Best M.D.</u>   | 22b. ADDRESS<br><u>Higginsville Mo.</u>  | 22c. DATE SIGNED<br><u>3/21/59</u>                      |        |       |

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                         | 23b. DATE<br><u>Mar. 21, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>City Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>Higginsville, Mo.</u> |
| 24. FUNERAL DIRECTOR<br><u>Wieggers-Rieckhof, Higginsville Mo</u> |                                   | 25. DATE RECD. BY LOCAL REG.<br><u>4-14-59</u>             | 26. REGISTRAR'S SIGNATURE<br><u>Maura E. Eastlund</u>                     |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service, 00, -57, All diseases in Part I must be causally related.

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 *Forest Rickhof* .....

Licensed Embalmer No. *4284* .....

P. O. Address *Stagnerville, 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.