

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037964

INDEXED

Registration District No. 113 Primary Registration District No. 5420 Registrar's No. 67 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Clair, Mo. R#1</u>		Length of stay in 1b ----	c. CITY OR TOWN <u>St. Clair, Mo. R#1</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALBERT</u> Last <u>STAHLMAN</u>	4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1960</u>
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5. SEX <u>Male</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 17, 1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	11. BIRTHPLACE (City and state or country) <u>Franklin County</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Julius Stahlman</u>	13b. MOTHER'S MAIDEN NAME <u>Louisa Everett</u>	14. NAME OF HUSBAND OR WIFE <u>Emma</u>
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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 <u></u> Address <u></u>
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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>Myo Cardial In Fraction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cardiac De compensation &amp; Hypertrophy</u>	
	DUE TO (c) <u>Cardio - Vascular - Renal Disease</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>In Sinistries</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u> <u></u> <u></u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from Sept 7, 1960 to Oct 15, 1960 and last saw him alive on Oct 14, 1960  
Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. J. M. Williams D.O.</u> (Degree or title)	22b. ADDRESS <u>445 S. Main St. St. Clair, Mo.</u>	22c. DATE SIGNED <u>10-17-60</u>
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23a. BURIAL, CREATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 18, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anaconda Cemetery</u>	23d. LOCATION (City, town, or county) <u>Anaconda, Missouri</u>
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24. FUNERAL DIRECTOR <u>Sherrill W. Kitchell St. Clair, Mo.</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u></u>	26. REGISTRAR'S SIGNATURE <u></u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 7 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Sherrill W. Kitchell

Licensed Embalmer No. 3873

P. O. Address H. Clair

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.