

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

89 -61-004782
STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 89

AMENDED

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Advance Mo. R 1		c. CITY OR TOWN Near Delta Mo.	
Length of stay in lb 10 yr		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Francis Hospital		d. STREET ADDRESS (If outside, give location) Advance R 1 (Mail)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Rose Mary Catherine Stoffregen			4. DATE OF DEATH Month Day Year Feb 26 1961		
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH June 5 1916- 44	9. AGE (last birthday) Months Days Hours Min. 8 21	IF UNDER 1 YEAR	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Factory	10b. KIND OF BUSINESS OR INDUSTRY International Co	11. BIRTHPLACE (City and state or country) Morley Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME Bryan Myers	13b. MOTHER'S MAIDEN NAME Myrtle Hutton	14. NAME OF HUSBAND OR WIFE Frank Stoffregen
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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) no	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address Frank Stoffregen Advance R 1
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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) Pulmonary Embolis		INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Auricular Fibrillation		12 days
DUE TO (c) Mitral Stenosis		Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Viral Pneumonia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from Feb. 13, 1961 to Feb. 26, 1961 and last saw her ^{her} _{him} alive on Feb. 26, 1961
Death occurred at 8:40 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edward D Campbell M.D.	22b. ADDRESS Cape Girardeau, Missouri	22c. DATE SIGNED 2-27-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-28-61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) Cape Girardeau Mo.
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24. FUNERAL DIRECTOR ADDRESS Brinkopf Howell Cape Gir Mo.	25. DATE RECD. BY LOCAL REG. 3-4-61	26. REGISTRAR'S SIGNATURE Drew Kasten
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

THIS IS TO CERTIFY THAT THE BODY OF _____
WAS EMBALMED BY ME OR BY _____
A. S. U. _____

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 Neil H. Grosche

Licensed Embalmer No. 4994

P. O. Address Cape Girardeau,

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.