

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013434

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 228 Primary Registration District No. 200 Registrar's No. 381A

FILED MAY 1 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>7 days</u>	c. CITY OR TOWN <u>Rt. 2, Strafford</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>Burge-Prot. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Jackson Township</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LESLIE</u> Middle <u>CARL</u> Last <u>STOGSDILL</u>			4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</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>2/9/1893</u>
9. AGE (last birthday) <u>68</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owned Service Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas & Oil Station</u>	11. BIRTHPLACE (City and state or country) <u>Cabool, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Newton Stogsdill</u>	
13b. MOTHER'S MAIDEN NAME <u>Lula Jones</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Alice Stogsdill</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> <u>None</u>		17. INFORMANT <u>Bertha Alice Stogsdill, Strafford, Mo.</u> Address <u>R.F.D. # 2</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>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
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 location of injury in PART I or PART II of item 18.)	
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 checked="" 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>9-11-61</u> to <u>9-14-61</u> and last saw him alive on <u>9-14-61</u> Death occurred at <u>3:45 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. Simpson</u> (Degree or title)		22b. ADDRESS <u>Springfield 2 Mo.</u>	22c. DATE SIGNED <u>9-26-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/16/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson, Iowa</u>
24. FUNERAL DIRECTOR <u>Ralph Thieme, Springfield, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-28-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Keith Collier*

Licensed Embalmer No. 3632

P. O. Address *Springfield*

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.