

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-013230

FILED APR 6 1962

318

1003

3118

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

VS 300 Rev. 4/59	DATE AMENDED
1	
28/20	27
3	
4	0
5	2
6	
7	1
8	2
9	
10	
11	
1255-0	
13	
55	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		Length of stay in lb 2Days	c. CITY OR TOWN Benton, Ill Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glennon Memorial		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 704 No Oak Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William Rea Stotlar			4. DATE OF DEATH Month Day Year 3/ 21 62
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/9/62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (last birthday) 5 yrs IF UNDER 1 YEAR Months Days Hours Min. 1 7
11. BIRTHPLACE (City and state of country) Illinois		12. CITIZEN OF WHAT COUNTRY US	
13a. FATHER'S NAME Ted K Stotlar		13b. MOTHER'S MAIDEN NAME Sue J (Rea)	
14. NAME OF HUSBAND OR WIFE None		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. None		17. INFORMANT Ted Stotlar, Benton, Ill. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Treacher-Collins Syndrome DUE TO (b) Asphyxia due to asperation DUE TO (c) 758.2 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 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 COUNTY STATE
21. I attended the deceased from March 20 to March 21 and last saw ^{her} him alive on March 21, 1962 Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Raymond H. Helweg, M.D.		22b. ADDRESS 1465 S. Grand Ave.	22c. DATE SIGNED 3-21-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-23-62	23c. NAME OF CEMETERY OR CREMATORY Masonic & Odd Fellows	23d. LOCATION (City, town, or county) (State) Benton, Ill.
24. FUNERAL DIRECTOR ADDRESS John Mitchell, Benton, Ill.		25. DATE RECD. BY LOCAL REG. MAR 22 1962	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Handwritten notes:
Coroner
3-23-62
Treasurer - Collins Syndrome
Asphyxia due to asperation
758.2

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 John Cassidy

Licensed Embalmer No. 5039

P. O. Address E. St Louis, 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.