

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22927
Do not use this space.

FILED JUL 15 1940

1. PLACE OF DEATH Saline 3
 (a) County Saline Registration District No. 796
 (b) Township 0 Primary Registration District No. 3038 Registered No. 105
 (c) City Marshall (d) Street No. Mo State School St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 18 yrs. 8 mos. 11 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 365 / Lattie Stranghan
 (a) Residence, No. Mo State School St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF W. K.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10, 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 1 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as saw mill, bank, etc. Domestic
 10. Date deceased last worked at this occupation (month and year) - 11. Total time (years) spent in this occupation -

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Francois, Mo

FATHER 13. NAME W. K. 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. K.

MOTHER 15. MAIDEN NAME W. K. 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W. K.

17. INFORMANT (ADDRESS) Robert Reed, Marshall

18. BURIAL, CREMATION, OR REMOVAL PLACE Mo. State School 7-2-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Hershberger, Marshall, Mo.

20. FILED 7-1-40 19. 40 Marshall, Mo. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30, 1940

22. I HEREBY CERTIFY That I attended deceased from May 1, 1940 to June 30, 1940
 I last saw her alive on June 30, 1940 Death is said to have occurred on the date stated above, at 6:50 m.
 The principal cause of death and related causes of importance were as follows:
Endocarditis chronic

Date of onset

Other contributory causes of importance: 92W

Name of operation No Date of No
 What test confirmed diagnosis? Clinical (there an autopsy?) No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? - Date of injury -, 19-
 Where did injury occur? - (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. -
 Manner of injury -
 Nature of injury -

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify -
 (Signed) H. Hershberger M. D.
 (Address) Marshall

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-11-40

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed Felix Benz
Licensed Embalmer No. H127
P. O. Address Marshall, W

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 this body is not embalmed, above space should be left blank.