

V. S. No. 2
DM-9-4-41
5-17-39
PI X2945

24996

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 5 1948

Registrar's No. 596

Registration District No. 22/28

Primary Registration District No. 5465

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1. PLACE OF DEATH:
 (a) County GREENE
 (b) City or town Rural Springfield N. Campbell
 (c) Name of hospital or institution: Route #5
 (d) Length of stay: Over 60 years
 In this community Over 60 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Rural Springfield N. Campbell
 (d) Street No. Route #5
 (e) Citizen of foreign country? No

3. (a) PRINT FULL NAME AL VARO STRALEY
 3. (b) If veteran, name war Hub
 3. (c) Social Security No. None

4. Sex Male Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Elizabeth Straley
 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased October 8, 1863

8. AGE: Years 79 Months 9 Days 16
 If less than one day: _____ hr. _____ min.

9. Birthplace DeCora Iowa

11. Industry or business Own a Confectional Stand

12. Name Robert Lester Straley
 13. Birthplace Unknown Pa.
 14. Maiden name Catherine Shank
 15. Birthplace Unknown Unknown

16. (a) Informant Mr. R. N. B. Shank
 (b) Address 706 W. Walnut

17. (a) Burial Greenlawn Cemetery
 (b) Date thereof 7-27-43
 (c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director F. C. Thieme
 (b) Address 1100 Boonville St., City

19. (a) 7-26-43 (Date received local registrar)
 (b) F. W. H. [Signature] (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 24th
 year 1943 hour Seven minute 30 A.

21. I hereby certify that I attended the deceased from 7-15 1943 to 7/24 1943
 that I last saw h. in alive on 7-23 and that death occurred on the date and hour stated above.

Immediate cause of death Acute heart block or coronary occlusion
 Duration 8 days

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: 95d
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature C. E. Fuller (M. D. or other)
 Address Springfield Mo. Date signed 7/26/43

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..... **Fred C. Thieme**.....

Licensed Embalmer No..... **2899**.....

P. O. Address..... **Springfield, Missouri**.....

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, fact should be so stated above.

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