S. No. 2
1—1-4-41
5-17-39
X2839

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31272

FILED SEP 24 1943

Registration District No. 42

Primary Registration District No. ~~1001~~ 1000

Registrar's No. 1003

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

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2, 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs 6 mo (Specify whether years, months or days)

In this community Same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt County

(c) City or town Mound City
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Maude-Strough.

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race W.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 4 (Month) 18 (Day) 1892 (Year)

8. AGE:

Years	Months	Days	If less than one day
51	4	11	hr. min.

9. Birthplace Holt Co. Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business —

FATHER
12. Name Abraham Strough
13. Birthplace ~~Indiana~~ Virginia
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth May
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant State Hosp Records
(b) Address St Joseph Mo

17. (a) Rem. (Burial, cremation, or removal) (b) Date thereof 8-28-43 (Month) (Day) (Year)
(c) Place: burial or cremation Oregon, Mo

18. (a) Signature of funeral director James H Pittzjah
(b) Address Oregon Mo.

19. (a) 8-28-43 (Date received local registrar) (b) Rose Herzog (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 28th year 1943 hour 7 minute P M.

21. I hereby certify that I attended the deceased from 2/17/41, 19 to 8/28/43, 19 ; that I last saw h alive on 8/24/43, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage, Cardiac Decompensation	
Due to Hypertension	
Due to	
Other conditions Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	
Major findings: Of operations —	
Of autopsy —	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature L H Denham MD (M.D. or other)

Address St Joseph Mo Date signed 7/29/43

1233

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ will be embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed James H Pittijah

Licensed Embalmer No. 3092

P. O. Address Oregon Ills

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.