

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35931

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. _____

REC'D NOV 12 1943

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 195

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 hours 0
(Specify whether years, months or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper 149
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Route 4, Carthage
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - - 1

3. (a) PRINT FULL NAME Joseph Charles Struewing
3. (b) If veteran. name war No 3. (c) Social Security 486-20-3872

4. Sex Male 0 5. Color or race White 0
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive - - - years
7. Birth date of deceased April 9 1926
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 6 7 hr. min.

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

10. Usual occupation Student

11. Industry or business St. Peter's High School

12. Name E. J. Struewing

13. Birthplace Covington 1 Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Edna Frechin

15. Birthplace Girard 1 Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant E. J. Struewing

(b) Address Route 4, Carthage, Mo.

17. (a) Burial (b) Date thereof Oct. 19, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Missouri

19. (a) Oct. 18 '43 (b) Elizabeth Couplin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1943 hour 9.05 minute A M.

21. I hereby certify that I attended the deceased from _____
_____ 19____ to _____ 19____
that I last saw Direct saw him alive
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Due to Hyper tension
Due to Right fracture in vertex of skull
Other conditions (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations Skull fracture
Of autopsy Wedge cerebral hemorrhage

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?

While at work? _____ (Specify type of place)
(c) Means of injury Car

23. Signature E. J. Struewing (M. D. or other)
Address Carthage, Mo. Date signed Oct 17

MOTHER FATHER

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

1005

(Licensed Embalmer's Statement on Reverse Side)

43

48-10-926

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..... *Emmal Stuell*

Licensed Embalmer No. *391*

P. O. Address..... *Carthage 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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2201.

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

1. PLACE OF DEATH:

(a) County Gasper
 (b) City or town Carthage
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: McLure Brooks - Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 hr. (Specify whether
 In this community 17 yr. years, months or days)

3. (a) PRINT FULL NAME Joseph C. Struewing
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 446-20 3872

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: April 9 1922
 (Month) (Day) (Year)

8. AGE: Years 17 Months 6 Days 1 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Hypertension
Slight fracture in vertex of skull
 Due to Crack in vertex may have been caused by dropping cap at autopsy
 Other conditions: Hemorrhage in four cerebra of Willis
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy gza!

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) Ms. History of accident
 (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?

While at work? _____ (Specify type of place) Means of injury _____
 23. Signature P. H. Heston (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

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

MAR 16 1944

35031