

FILED MAR 20 1944

Registration District No. 333

Primary Registration District No. 3074 6115

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Rural Ridland
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community life years, months or days) (Specify whether

3. (a) PRINT FULL NAME Stella Louise Strong

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race white 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: Born Feb 25 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 9 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation body

11. Industry or business _____

12. Name Noah Strong

13. Birthplace Frank Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Edith Norton

15. Birthplace Leflore Co. Okla
(City, town, or county) (State or foreign country)

16. (a) Informant Noah Strong

(b) Address Vanduser Mo

17. (a) Burial (b) Date thereof 12-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carpenter

18. (a) Signature of funeral director W. L. Strong

(b) Address Sublet Mo

19. (a) 2/5/44 (b) Louise Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott

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

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 year 1943 hour 4 minute A.M.

21. I hereby certify that I attended the deceased from 12-10 to 12-13-43

that I last saw her alive on 12-13-43 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

from

Due to Whooping Cough

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy no

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) (e) Means of injury _____

23. Signature M. D. Mayfield (M. D. or other) _____
Address Vanduser Mo Date signed 12-17-44

Duration
4 days
4 10/100
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Office No. 2

District File Number 344-507

Date Filed 3-16-44

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.

not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.