

FILED MAY 10 1944

Registration District No. 277

Primary Registration District No. 3948

Registrar's No. 251

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Rural - Ashley
(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 no
In this community 80-5-1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike
(c) City or town Rural
(d) Street No. Near Ashley
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Louis A. Strother

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida Kendall Strother 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased no. 22 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 1 If less than one day hr. min.

9. Birthplace Pike Co. - Ashley Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name Ruben G. Strother

13. Birthplace R.K. Va. 1
(City, town, or county) (State or foreign country)

14. Maiden name Jemima Bunnell

15. Birthplace R.K. Va. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Ida Strother

(b) Address Ashley Mo

17. (a) Burial (b) Date thereof 4-27-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashley Mo.

18. (a) Signature of funeral director H. B. Elmore

(b) Address Bowling Green

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23
year 1944 hour 1 minute _____ M.

21. I hereby certify that I attended the deceased from June 1, 1944, to April 23, 1944
that I last saw him alive on April 28, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency Duration 10 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations None

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? (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) _____ (b) Means of injury _____

23. Signature M. W. Weather (M. D. or other) _____

Address Bowling Green Mo Date signed 4/24/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 5-44-911

Date Filed MAY 9 1944

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.....

H. B. Chace

Licensed Embalmer No.

3466

P. O. Address.....

Banking Green

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. May
Registrar's No. 21

Registration District No. 277 Primary Registration District No. 5948

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Rural Ashley Twp.
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Louis A. Strotter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Nov. 22 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days _____ If less than one day _____ min.

9. Birthplace mo
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) May 1 - 1944 (b) Mrs Frank Loda
(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 _____

20. DATE OF DEATH: Month April 3
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above. (Immediate cause of death)

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
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? _____ (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. or other) _____
Address _____ Date signed _____

MEDICAL CERTIFICATION
TENTATIVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

15504