

FILED MAY 9 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registrar's No. 13

Registration District No. 112

Primary Registration District No. 3428

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Boone Township
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Paul Rodyer Strause

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 _____

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

7. Birth date of deceased 3 - 26 - 46
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 16 hr. _____ min.

9. Birthplace Boone Township Franklin Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Charles O Strause

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

14. Maiden name Mable Adell

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

16. (a) Informant Charles O Strause

(b) Address Springbluff Mo

17. (a) BURIAL (b) Date thereof 3 - 27 - 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation cone Spring

18. (a) Signature of funeral director none
(b) Address _____

19. (a) 4-23-46 (b) J. Matthews
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 27
year 46 hour 6:30am minute _____ M.

21. I hereby certify that I attended the deceased from 3 - 26
1946 to _____ 19____

that I last saw him alive on 3 - 26 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Premature baby 6 1/2 mo.

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 J W Taylor (M. D. or other) MO
Address Sublimian MO Date signed 4-4-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 5-8-46

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.....

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.