

FILED SEP 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

29164  
 State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 218

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville, Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>New Hartford, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Laughlin Hospital</u>		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Minnie</u> b. (Middle) _____ c. (Last) <u>Stroker</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9 11 49</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-18-1897</u>
9. AGE (In years last birthday) <u>52</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Unknown PIKE Co Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Samuel Davidson</u>	
13b. MOTHER'S MAIDEN NAME <u>Mollie Hitchcock</u>		14. NAME OF HUSBAND OR WIFE <u>Clark Stroker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Clark Stroker</u>		ADDRESS <u>New Hartford, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Perforation of ulcerative colitis with widespread peritonitis.</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Extensive ulcerative colitis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Myocardial weakness and tularemia</u> Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION <u>no</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>8-26-49</u> , 19 <u>49</u> , to <u>9-11-49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-10-49</u> , 19 <u>49</u> , and that death occurred at <u>10:08 Pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Carl Neeghen Jr.</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>Kirksville, Mo.</u>	
23c. DATE SIGNED <u>9-11-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	
24b. DATE <u>9-12-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Hartford Church New Hartford Mo.</u>	
24d. LOCATION (City, town, or county) (State) _____		DATE REC'D BY LOCAL REG. <u>9-12-49</u>	
REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Kunk</u> ADDRESS <u>Bowling Green Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

SEP 19 1949

District Health Officer No. 10

District File Number 7-42-1629

Date Filed SEP 19 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Harold C. Kink

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4597

P. O. Address Bowling Green, W.

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.