

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26413

State File No.

FILED SEP 13 1950

BIRTH NO. 48100-50 REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Boonville	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 1112 Hickam St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

0279
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3. NAME OF DECEASED (Type or Print)	a. (First) Elizabeth	b. (Middle) Ann	c. (Last) Stretz	4. DATE OF DEATH (Month) (Day) (Year) September 3 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH September 3rd 1950	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 18 HRS. Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boonville, Missouri.		12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Robert Stretz	13b. MOTHER'S MAIDEN NAME Betty Lou Murray	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Robert Stretz ADDRESS Boonville, Missouri.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 7620
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital atelectasis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Transposition of heart to right side of chest.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10:30 to 2:30 A.M. on 9-2-50, 1950, to 9-3-50, 1950, that I last saw the deceased alive on 9-2-50, 1950, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE Howard P. Hillen, M.D. (Degree or title)	23b. ADDRESS Boonville, Missouri.	23c. DATE SIGNED 9-5-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 3rd 1950	24c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	24d. LOCATION (City, town, or county) (State) Boonville, Missouri.
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DATE REC'D BY LOCAL REG. 9-9-50	REGISTRAR'S SIGNATURE SD Hooper 381	25. FUNERAL DIRECTOR'S SIGNATURE Goodman & Boller, Boonville, Missouri. ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-12-5
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 9-12-50

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 _____

working under my personal supervision.

Not Embalmed

Student Embalmer No.

Signed _____

Signed
Student Embalmer

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.