

FILED JUN 20 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21765

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 6084 Registrar's No. 115

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Blackwater Twp</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Houstonia Mo. P.7.D.#1</u>	
c. LENGTH OF STAY (In this place) <u>50 Yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Houstonia P.7.D.#1</u>			

3. NAME OF DECEASED (Type or Print) <u>Lee STRATTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 6 1951</u>		
a. (First) <u>Lee</u>		b. (Middle)	c. (Last)		

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 6-1869</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MINS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Owner</u>	11. BIRTHPLACE (State or foreign country) <u>Osage Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Thomas Fleming Stratton</u>	13b. MOTHER'S MAIDEN NAME <u>Susan E. Zevell</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	(If yes, give war or date of service)	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ether Stratton</u>	ADDRESS <u>Houstonia</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremic Coma,</u>	DUPLICATE OF (b) <u>Aortic Incompetency,</u>		<u>24 Hours</u>
ANTECEDENT CAUSES	DUPLICATE OF (c) <u>Chronic Glomerulonephritis</u>		<u>7 Days</u>
II. OTHER SIGNIFICANT CONDITIONS	DUPLICATE OF (d) <u>Chronic Glomerulonephritis</u>		<u>1 Year</u>

*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 June 1 19 51, to June 6 19 51, that I last saw the deceased alive on June 6 19 51, and that death occurred at 11, 20 p from the causes and on the date stated above.

23a. SIGNATURE <u>John M. Meiss, D.D.</u>	(Degree or title)	23b. ADDRESS <u>092 Marshall, MO</u>	23c. DATE SIGNED <u>6-9-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-9-51</u>	24c. NAME OF CEMETERY OR CRYPTORY <u>Bethlehem</u>	24d. LOCATION (City, town, or county) (State) <u>Saline Co Mo</u>
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DATE REC'D BY LOCAL REG. <u>6-9-51</u>	REGISTRAR'S SIGNATURE <u>Aldrey Gray</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u>	ADDRESS <u>Sedalia Mo</u>
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 6-18-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 6-19-51 _____

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.

Student
Student Embalmer

Signed _____

J.P.M. Coary

Licensed Embalmer No. 3153

P. O. Address *Sedalia Mo*

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.