

No. 300-10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7467

FILED MAR 17 1952

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 263

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Missouri Methodist Hospital		d. STREET ADDRESS (If rural, give location) 5518 King Hill Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) ALICE b. (Middle) c. (Last) STROCK			4. DATE OF DEATH (Month) (Day) (Year) March 5, 1952			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Dec. 28 1862	9. AGE (In years last birthday) 89	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Elkhart Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Thomas Matteson	13b. MOTHER'S MAIDEN NAME Laura Rich	14. NAME OF HUSBAND OR WIFE James. M. Strock
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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) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. W. H. Miller	ADDRESS 5518 King Hill Ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemor		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chor Hypertension DUE TO (c) Ch. Gen. Cerebral Sclerosis			Unknown
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X			Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	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 **March 5, 1952**, to **March 5, 1952**, that I last saw the deceased alive on **March 5, 1952**, and that death occurred at **7:00 m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. P. Jernigan	23b. ADDRESS 48 734 Jell Ave	23c. DATE SIGNED 3/6/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 7, 1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. Mar. 10, 1952	REGISTRAR'S SIGNATURE Carl C. Casutt	446	25. FUNERAL DIRECTOR'S SIGNATURE Earle Clark	ADDRESS 2011 Missis
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(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. 4235

P. O. Address St. Joseph 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.