

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14805**

No. 300
10.48

FILED APR 20 1953
BIRTH NO. 15747

REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 5607 Registrar's No. 14

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

1. PLACE OF DEATH a. COUNTY Johnson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Johnson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Kingsville Twp		c. LENGTH OF STAY (In this place) 3 Days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Holden, Mo. 0510			
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location) Route 4			
3. NAME OF DECEASED (Type or Print) a. (First) Sandra		b. (Middle) Lee	c. (Last) Stretch	4. DATE OF DEATH (Month) (Day) (Year) April 3 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 21 1953	9. AGE (In years last birthday) 12	IF UNDER 1 YEAR Months 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Russell Stretch		13b. MOTHER'S MAIDEN NAME Naomi Hobbs		14. NAME OF HUSBAND OR WIFE ---		
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 ADDRESS Russell Stretch, Holden, Missouri		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cryptal meningococci ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 751X		
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 Mar 21, 1953 to April 3, 1953 , that I last saw the deceased alive on April 3, 1953 , and that death occurred at 7:40P m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) James M. Holmberg Sr. Holden Mo			23b. ADDRESS Holden Mo		23c. DATE SIGNED 4/4/53	
24a. BURIAL, CREMATION REMOVAL (Specify) Burial		24b. DATE 4-4-1953	24c. NAME OF CEMETERY OR CREMATORY Scotland Cemetery		24d. LOCATION (City, town, or county) (State) Daviess County, Missouri	
DATE REC'D BY LOCAL REG. 4-9-1953		REGISTRAR'S SIGNATURE Mrs. James Redford		25. FUNERAL HOME'S SIGNATURE ADDRESS Hope Funeral Home, Gallatin, Mo.		

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JOHNSON COUNTY HEALTH DEPT.

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

L. O. Peterson

Licensed Embalmer No. *3302*

P. O. Address

Gallatin, M.

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.