

No. 300
10.48

55110

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22078

State File No.

FILED JUL 7 - 1953

BIRTH NO. _____ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY <u>LAWRENCE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>LAWRENCE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Aurora, Mo.</u>		c. LENGTH OF STAY (In this place) <u>UNKNOWN</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aurora Hospital</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Billing</u>	
		d. STREET ADDRESS (If rural give location) <u>R.F.D. 2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Jessie</u> b. (Middle) <u>May</u> c. (Last) <u>Strohfield</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 3-1953</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>April 14-1904</u>	9. AGE (In years last birthday) <u>49</u>	Months <u>6</u> Days <u>19</u> Hours <u></u> Min. <u></u>
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 <u>AT HOME</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>OKlahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>

13a. FATHER'S NAME <u>HENDERSON HARMON</u>		13b. MOTHER'S MAIDEN NAME <u>Connie Strain</u>		14. NAME OF HUSBAND OR WIFE <u>C.W. Strofield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>C.W. Strofield Billings R-2</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Malignant Hypertension</u> DUE TO (b) <u></u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>26 years</u>
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</u>	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 10/6 to June 3, 1953, that I last saw the deceased alive on June 3, 1953 and that death occurred at 4:30 m. (from the causes and on the date stated above.

23a. SIGNATURE <u>A.P. Copetti</u> (Degree or title) <u>D.M.D.</u>	23b. ADDRESS <u>Aurora, Mo.</u>	23c. DATE SIGNED <u>6-4-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/5/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>OSR CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>8 miles south of Aurora, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>7-2-1953</u>	REGISTRAR'S SIGNATURE <u>Oran M. Watt</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edwin L. Marsh Aurora, Mo.</u>
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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 _____

Myself _____, Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed *Robert E. Mableman* _____
Licensed Embalmer No. *4916* _____
P. O. Address *Aurora, 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.