No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27521
State File No.

FILED JUL 28 1953

BIRTH NO. REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 130

1. PLACE OF DEATH
a. COUNTY Vernon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wash Township
c. LENGTH OF STAY (In this place) 14y 9m 5d.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hosp 3 Nevada Mo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Mo
b. COUNTY Stone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Billings 1040
d. STREET ADDRESS (If rural, give location) R R 1

3. NAME OF DECEASED (Type or Print)
a. (First) VIOLA
b. (Middle) —
c. (Last) STRAUB

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1953

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH July 6, 1887
9. AGE (In years last birthday) 65
If under 1 year: Months 11 Days 27
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 none
11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Dr W. Z. Allen
13b. MOTHER'S MAIDEN NAME Jane Owens
14. NAME OF HUSBAND OR WIFE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Records State Hosp 3 Nevada Mo ADDRESS

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) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental Deficiency

19a. DATE OF OPERATION no
19b. MAJOR FINDINGS OF OPERATION none
4201
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no
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 ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1939, *to* July 3, 1953; *that I last saw the deceased alive on* July 3, 1953, *and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul L. Barone (Degree or title) M.D
23b. ADDRESS State Hosp 3 Nevada Mo
23c. DATE SIGNED July 3/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/6/53
24c. NAME OF CEMETERY OR CREMATORY Hospital Cemetery
24d. LOCATION (City, town, or county) (State) Nevada, Mo.

DATE REC'D BY LOCAL REG. 7-25-53
REGISTRAR'S SIGNATURE Anna E Ferry 451
25. FUNERAL DIRECTOR'S SIGNATURE Ed Wilson Funeral Home Nevada ADDRESS Mo

(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 Visit

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed Marsh Eichinger

Licensed Embalmer No. 5/2656

P. O. Address Nevada 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.