

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 1 - 1953

BIRTH NO. _____ REG. DIST. NO. 112 PRIMARY REG. DIST. NO. 5428 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY FRANKLIN	
b. CITY OR TOWN RURAL BOONE		c. CITY OR TOWN RURAL BOONE	
c. LENGTH OF STAY (In this place) 2yr.		d. STREET ADDRESS (If rural, give location) RURAL OF SULLIVAN MO.	
d. FULL NAME OF HOSPITAL OR INSTITUTION RURAL OF SULLIVAN MO			

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) LEE c. (Last) STRAUSER			4. DATE OF DEATH (Month) (Day) (Year) 7-30-1953		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH 1-21-1891		9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR: Months 6 Days 9 IF UNDER 24 HRS. Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (City and State or Foreign Country) SPRING BLUFF MO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME G. W. STRAUSER		13b. MOTHER'S MAIDEN NAME SUSAN MOSS		14. NAME OF HUSBAND OR WIFE ROSE E STRAUSER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 488-07-6495		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS ROSE STRAUSER SULLIVAN MO	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 6 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Thrombosis</u>		ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 July 24, 1953 to July 30, 1953, that I last saw the deceased alive on July 29, 1953 and that death occurred at 3:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Delatone M.D.		23b. ADDRESS Sullivan, Mo		23c. DATE SIGNED 7/31/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 8-2-1953		24c. NAME OF CEMETERY OR CREMATORY CAVE SPRINGS CEMETERY	
		24d. LOCATION (City, town, or county) (State) FRANKLIN MO.			

DATE REC'D BY LOCAL REG. 8-1-53		REGISTRAR'S SIGNATURE H. Matthews		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thos. J. Shaffer Sullivan Mo	
---	--	---	--	---	--

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

No. 300
10.48

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Paul F. Knollenber

Licensed Embalmer No. 2631

P. O. Address Sullivan 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.