

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017017

STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 333 Primary Registration District No. 8074 Registrar's No. 62

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>New Madrid</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Lilbourn</b> <b>0720</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hosp.</b> Length of stay in lb <b>2 Days</b>		d. STREET ADDRESS <b>Route #1</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leon</b> Middle <b>Benton</b> Last <b>Strong</b>			4. DATE OF DEATH Month <b>4</b> Day <b>1</b> Year <b>1958</b>
5. SEX <b>Male</b> <b>0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-1902</b>
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Perry Co., Arkansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>S. H. Strong</b>	
14. MOTHER'S MAIDEN NAME <b>Myrtle Vaught</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Helen Strong, Lilbourn, Mo.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>4201</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>① Uremia, Chronic</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <b>Jan 1 1958</b> to <b>4-1-58</b> and last saw <del>him</del> <b>him</b> alive on <b>4-1-58</b> . Death occurred at <b>5:25 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Audrey B. Smith M.D.</b> <b>0</b>		22b. ADDRESS <b>Sikeston, Mo.</b>	22c. DATE SIGNED <b>4-2-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-3-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Little Prairie Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Carruthersville, Mo.</b>
24. FUNERAL DIRECTOR <b>Ponder Funeral Home-Lilbourn, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-7-58</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Ellen Hunter</b>

(Licensed Embolmer's Statement on Reverse Side)

DATE RECEIVED APR 14 1958

SCOTT CO. HEALTH DEPT.

CO. FILE No. 458-94

APR 22 1958

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.....  
Signature of Student Embalmer

Signed David H. Ponder.....

Licensed Embalmer No. 503

P. O. Address Lithour, S.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.