

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020138
STATE FILE NUMBER

FILED JUN 5 1959 Registration District No. 391 Primary Registration District No. 4505 Registrar's No. 11

S. 300
- 1-57

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bell City</u>		c. CITY OR TOWN <u>Bell City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE TWP.</u>		d. STREET ADDRESS (If outside, give location) <u>1030</u>	
Length of stay in lb <u>10 yr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha E Strobel</u>			4. DATE OF DEATH Month Day Year <u>April 23 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 19, 1888</u>	9. AGE (In years last birthday) <u>71</u>	10. F UNDER 1 YEAR Months <u>1</u> Days <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	11. BIRTHPLACE (City and state or country) <u>Swinton, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>H. N. Mann</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Elmer Strobel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Elmer Strobel, Bell City, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Anoxia</u>		<u>4 hours</u>
DUE TO (c) <u>Cerebral thrombosis</u>		<u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</u>		

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.) <u>332X</u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 10-58 to 4-23-59 and last saw her alive on 4-21-59
Death occurred at 11:05 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>D. G. Mustice Sr.</u>	22b. ADDRESS <u>Advance Mo 4-24-59</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maryon</u>	23d. LOCATION (City, town, or county) (State) <u>Advance, Mo.</u>
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24. FUNERAL DIRECTOR <u>Wm J Maryon</u>	ADDRESS <u>Advance Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4/25/59</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Moore</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Wm H. Mary*

Licensed Embalmer No. *4640*
P. O. Address. *Adverse, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.