

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028874

FILED VS AUG 24 1959

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mound City</u>		Length of stay in 1b <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Marionville</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>150 N. Depot</u>	

3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>Robert</u> Last <u>Strough</u>			4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1959</u>		
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5. SEX <u>male</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>3-18-1902</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retailer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Strough Tobacco Store Dotham Mo</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>Philip Strough</u>	13b. MOTHER'S MAIDEN NAME <u>Marie K. Kahler</u>	13c. NAME OF HUSBAND OR WIFE <u>Dorothy Strough</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war and dates of service) <u>WWII</u>	16. SOCIAL SECURITY NO. <u>493-18-4715</u>	17. INFORMANT address <u>Mrs. Dorothy Strough, Marionville, Mo.</u>
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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>Myocardial infarction</u> DUE TO (b) <u>Arterial insufficiency (myocardial)</u> DUE TO (c) <u>arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>History of previous head attacks.</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
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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 4:30 8/18/59 to 4:45 8/18/59 and last saw her/him alive on never
 Death occurred at 4:45 PM 1959 - (Pronounced) on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James Humphreys M.D.</u>	22b. ADDRESS <u>Marionville, Mo.</u>	22c. DATE SIGNED <u>8/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Marion Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Marionville Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Bob Stehman Marionville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/21/59</u>	26. REGISTRAR'S SIGNATURE <u>James Bradford</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6961 9 T 250

6961 4 T 250

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed G. M. Atkinson

Licensed Embalmer No. 2279

P.O. Address Manjor

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.