

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 13 1960

60-000039

STATE FILE NUMBER

Registration District No. 2 Primary Registration District No. 5017 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nodaway</u>		Length of stay in 1b <u>6 weeks</u>	c. CITY OR TOWN <u>Grant City</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jess</u> Middle <u>William</u> Last <u>Straley</u>			4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware and Farm</u>	11. BIRTHPLACE (City and state or country) <u>Oxford, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
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13a. FATHER'S NAME <u>Spencer Straley</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Payton</u>	14. NAME OF HUSBAND OR WIFE <u>Mabel Straley</u>
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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>Mrs. Julie Ellsworth-Nodaway, Missouri</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>ANOXIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CARDIAC VENTRICULAR FAILURE</u>	<u>2 WEEKS</u>
	DUE TO (c) <u>ARTERIO SCLEROSIS</u>	<u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC ASTHMA</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

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 <u> </u> Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u>Grant City, MO</u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from JAN 1956 to DEC. 21, 1959 and last saw her/him alive on DEC 21, 1959
Death occurred at 2:30 10 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Richard J. Dungee, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Grant City, MO</u>	22c. DATE SIGNED <u>1-2-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grant City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Grant City, Missouri</u>
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24. FUNERAL DIRECTOR <u>Bill A. Dungee, Grant City, Mo</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>1-4-60</u>	26. REGISTRAR'S SIGNATURE <u>Lillian Sparks</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address: Grant City

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.