

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010739

FILED VS APR 4 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 53

ENDED

1. PLACE OF DEATH a. COUNTY HOWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY HOWELL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WEST PLAINS	Length of stay in 1b 2 YRS	c. CITY OR TOWN WEST PLAINS	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) LINCOLN AVE.
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last MARTHA ELLEN STRONG			4. DATE OF DEATH Month Day Year 3 24 1960		
5. SEX Fe.	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) OZARK CO., MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME WILLIAM SMITH		13b. MOTHER'S MAIDEN NAME NANCY DAVIS		14. NAME OF HUSBAND OR WIFE SAM STRONG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address SAM STRONG, WEST PLAINS, MO.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CEREBRAL ARTERIOSCLEROSIS		YEARS
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (1) HYPERTENSION, ESSENTIAL @ PREVIOUS CEREBRAL HEMORRHAGE		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.)
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 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

21. I attended the deceased from **11-15-57** to **3-24-60** and last saw her alive on **3-24-60**
Death occurred at **9:30 AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Signature of Informant) Jack P. Wilson, MD		22b. ADDRESS West Plains, Mo.		22c. DATE SIGNED 3-28-60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-26-1960	23c. NAME OF CEMETERY OR CREMATORY PATRICK	23d. LOCATION (City, town, or county) (State) OZARK CO, MISSOURI	
24. FUNERAL DIRECTOR ADDRESS CLINKINGBEARD, GAINESVILLE, MO		25. DATE RECD. BY LOCAL REG. 3-29-60	26. REGISTRAR'S SIGNATURE Beatrice Cook	

(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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Usrey

Licensed Embalmer No. _____

P. O. Address _____

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.