

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026266

FILED VS JUL 25 1960

74

Registration District No. 5295-4136

Primary Registration District No. 25

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Plattsburg</u>		Length of stay in 1b <u>10 mo.</u>		c. CITY OR TOWN <u>Plattsburg</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 <u>211 1/2 BROADWAY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>211 1/2 BROADWAY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Eunice Stroup</u>				4. DATE OF DEATH Month Day Year <u>July 17 1960</u>				
5. SEX <u>female</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>2-27-1892</u>	9. AGE (last birthday) <u>88</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mont Rose Penna.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Frederick W. Bolles</u>			13b. MOTHER'S MAIDEN NAME <u>Julia Cook</u>			14. NAME OF HUSBAND OR WIFE		
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. R.N. PALMER</u>		Address <u>Plattsburg, MO.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>							<u>40 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>							<u>8-10 yrs</u>	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema + fibrosis, Chronic</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 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 a.m. p.m.		Month, Day, Year						
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 <u>Aug. 1953</u> to <u>July 1960</u> and last saw her alive on <u>July 17, 1960</u> Death occurred at <u>5:8 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22. SIGNATURE (Degree or title) <u>John P. Mabrey M.D.</u>				22b. ADDRESS <u>Plattsburg, Mo.</u>			22c. DATE SIGNED <u>July 18, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clifford township Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Butler County Kansas</u>				
24. FUNERAL DIRECTOR <u>Lyon Funeral Home Plattsburg, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>7-18-60</u>		26. REGISTRAR'S SIGNATURE <u>May W. Seener by Fay (attest)</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 26 1960

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 Phillip E. Coof

Licensed Embalmer No. 4992

P. O. Address Plattburg

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