SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-014399
STATE FILE NUMBER

AMENDED

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 11

FILED MAY 15 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Linn
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Marceline
Length of stay in 1b: 1 Mo
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Florence Rest Home
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Linn
c. CITY OR TOWN: Brookfield
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 522 S Livingston
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Josephine Middle: Pajovich Last:
4. DATE OF DEATH: Month 5 Day 10 Year 61
5. SEX: F
6. COLOR OR RACE: W
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 12-28-1878
9. AGE (last birthday): 83
IF UNDER 1 YEAR: Months 4 Days 12
IF UNDER 24 HR: 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:
11. BIRTHPLACE (City and state or country): Czechslovakia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Joseph Strayhall
13b. MOTHER'S MAIDEN NAME: Mary Ervi
14. NAME OF HUSBAND OR WIFE: Joseph (dec)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mary Andrews Address: 301 N Quincy Kansas City, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24-48 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Left hemiplegia, Severe Malnutrition — unknown
DUE TO (c): Generalized Arteriosclerosis, severe — indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 25 April 61 to 10 May and last saw (her) (him) alive on 9 May 61
Death occurred at 6 45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Glennon A Horner, MD
22b. ADDRESS: Marceline Mo
22c. DATE SIGNED:
23a. BURIAL, CREMATION, REMOVAL (Specify): B
23b. DATE: 5-12-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
23d. LOCATION (City, town, or county) (State): Marceline, Mo.
24. FUNERAL DIRECTOR: James McLaughlin ADDRESS: Marceline Mo
25. DATE RECD. BY LOCAL REG.: May 12-61
26. REGISTRAR'S SIGNATURE: Verna Watson

(Licensed Embalmer's Statement on Reverse Side)

MAY 26 1961

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 Gerald J. Wade

Licensed Embalmer No. 4172

P. O. Address Bronx

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.