

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030108

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. _____ Registrar's No. 28

AMENDED

FILED AUG 17 1961

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maywood, Route</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Maywood</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Patricia Ann Stratton</u>			4. DATE OF DEATH Month Day Year <u>Aug. 9, 1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/44</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (last birthday) <u>17</u> <input checked="" type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HR Months Days Hours Min. <u>6 20</u>
13a. FATHER'S NAME <u>Elmer Lee Stratton, Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>Esther Selves</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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>	14. NAME OF HUSBAND OR WIFE <u>never married</u>
17. INFORMANT <u>Mrs. Esther Stratton, Maywood, Mo.</u>		Address _____	
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>Cerebral Hemorrhage (massive)</u> DUE TO (b) <u>Vomiting - in which violent exertion was experienced</u> DUE TO (c) <u>chronic peptic ulcer syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>a fall from the bed to a hard floor striking the head</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			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>2 hrs -</u>
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 _____ 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>June 14 1961</u> to <u>8/9/61</u> and last saw her alive on <u>Aug 9-1961</u> Death occurred at <u>9 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Sam Buchanan D.O.</u>		22b. ADDRESS <u>114 E. Lafayette, Palmyra, Mo.</u>	22c. DATE SIGNED <u>8/10/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug. 12, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Durham Cemetery</u>	23d. LOCATION (City, town, or county) <u>Durham, Mo.</u> (State) _____
24. FUNERAL DIRECTOR <u>Feester-Garner, Philadelphia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-14-61</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lusk</u> <u>By Viola Bell, Secretary</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

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 *Ralph P. Clark*

Licensed Embalmer No. 4217
P. O. Address *Donnelly, Mo*

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.