

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-047751**

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 207 STATE FILE NUMBER

**FILED JAN 16 1962**

1. PLACE OF DEATH a. COUNTY <u>Macon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon</u>		Length of stay in-1b <u>13 Days.</u>	c. CITY OR TOWN <u>Macon</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>Samaritan Hbsp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>620 S. Rollins</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>-</u> Last <u>Strahm</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>26.</u> Year <u>1961</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>5/11/1865</u>	9. AGE (last birthday) <u>96</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Niles, Michigan</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jerome Brickell</u>		13b. MOTHER'S MAIDEN NAME <u>Abigail Collier</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased.</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>no.</u>	17. INFORMANT <u>Mrs. Flora Van Doren</u>		Address <u>Macon, 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>Cerebrovascular thrombosis</u>					<u>12 hrs</u>	
DUE TO (b) <u>Arteriosclerotic (cardiovascular) disease</u>						
DUE TO (c) <u></u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Arteriosclerotic Heart disease</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.)		
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 checked="" 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>Dec. 20</u> to <u>Dec. 24, 1961</u> and last saw her/him alive on <u>Dec. 24, 1961</u> Death occurred at <u>2:30</u> <u>P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>James E. Campbell MD</u>			22b. ADDRESS <u>Macon Mo</u>		22c. DATE SIGNED <u>1/5/62</u>	
23a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/28/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>R.R. Macon, Mo.</u>		
24. FUNERAL DIRECTOR <u>Lester Hutton</u>		ADDRESS <u>Macon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-5-62</u>	26. REGISTRAR'S SIGNATURE <u>Walter H. Neely</u>	

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF SHOULD READ

MEDICAL CERTIFICATION

**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 Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Macon, 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.