

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 272 Primary Registration District No. 3052 Registrar's No. 140016607 STATE FILE NUMBER

FILED APR 19 1965

VS 300
Rev. 4/59

1 0808

2 0800

3 2

4 1

5 2

6 Home

7 0

8 1

9744.2

10

11

12 1-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived prior to institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Smithton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Streit</u> Last <u>Streit</u>			4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1965</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>12-11-1882</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>_____</u>	11. BIRTHPLACE (City and state or country) <u>New Lebanon, Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>William F. Cordray</u>	
13b. MOTHER'S MAIDEN NAME <u>Medora Hutchinson</u>		14. NAME OF HUSBAND OR WIFE <u>John A. Streit</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 Address <u>Mr. Maurine Bluhm - Smithton, Mo</u>
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>RESPIRATORY FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
DUE TO (b) <u>NEUROMUSCULAR DISORDER</u>			<u>2 WKS</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)			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 checked="" 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>4-12-65</u> to <u>4-13-65</u> and last saw her <u>alive</u> on <u>4-13-65</u> Death occurred at <u>5:53</u> P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Glass M.D.</u> (Degree or title)		22b. ADDRESS <u>1609 S. LIMIT, SEDALIA MO</u>	22c. DATE SIGNED <u>4-14-65</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-16-1965</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>New Lebanon</u>	23d. LOCATION (City, town, or county) (State) <u>Cooper Co. MO</u>
24. FUNERAL DIRECTOR <u>McLaughlin Bros - Sedalia</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>April 16, 1965</u>	26. REGISTRAR'S SIGNATURE <u>Francis Shelby per M. Anderson</u>

(Licensed Embalmer's Statement on Reverse Side)

EMERALD

Or Glass

3 days
5 weeks

STATEMENT BY LICENSED EMBALMER
RESPIRATORY FAILURE
MENTUM ASCUTAR DISORDER

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 K.P. McCreary

Licensed Embalmer No. 3153

P. O. Address Sedalia, Mo.

4-13-52

4-13-52

4-15-52

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.

4-11-52

Robert F. McCreary