

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016371

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 54

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 9 1962

VS 300 Rev. 4/59	DATE AMENDED
10850	
20950	
3	
4 0	
5 1	
6	
7 1	
8 2	
9 194.8	
10	
11	
12 1-2	
13 1-0	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Waynesville</u>		Length of stay in lb <u>48 hours</u>	c. CITY OR TOWN <u>Swedeborg</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>Pulaski County Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Benton</u> Last <u>Strain</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 20 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>	9. AGE (last birthday) <u>85</u>
11a. FATHER'S NAME <u>Davey Crockett Strain</u>		11b. MOTHER'S MAIDEN NAME <u>Mary Gains</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Davey Crockett Strain</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Iona Strain</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>	17. INFORMANT <u>Lawrence Strain Swedeborg Missouri</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>Epithelioma of Lip and Neck</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pipe Smoking (Life Time)</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 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>1946</u> to <u>APRIL 25</u> and last saw ^{her} him alive on <u>APRIL 24</u> Death occurred at <u>1 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>John A. Mikalovich DO</u>		22b. ADDRESS <u>Crocker Missouri</u>	22c. DATE SIGNED <u>4/26/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-27-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crocker Memorial Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Crocker, Missouri</u>
24. COUNTY DIRECTOR <u>Moss-Williams Crocker Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-27-62</u>	26. REGISTRAR'S SIGNATURE <u>Paula Ora Anderson</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Clarence Moss

Licensed Embalmer No. 4896

P. O. Address Warrensville, 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.