

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STANDARD CERTIFICATE OF DEATH

APR 21 1941

Registration District No. 4419

Primary Registration District No. 5609

Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE Lebanon Mo.
(b) City or town RURAL Highway 32
(c) Name of hospital or institution: LEBANON TWP. HIGHWAY 32
(d) Length of stay: In hospital or institution
In this community OVER 40 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE
(c) City or town RURAL
(d) Street No. Highway 32
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME ROBERT STEWART STRATTON

3. (b) If veteran, name war. 3. (c) Social Security No. none

4. Sex M D 5. Color or race W 6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife NETTIE COURSER 6. (c) Age of husband or wife if alive 7 years

7. Birth date of deceased MAR 7-1858 (Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 21 If less than one day hr. min.

9. Birthplace BRITTON ILL (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

12. Name EDWARD B. STRATTON

13. Birthplace U.S. (City, town, or county) (State or foreign country)

14. Maiden name JANE STEWART (City, town, or county) (State or foreign country)

15. Birthplace IRELAND (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bert Stratton

(b) Address LEBANON MO PALM RT.

17. (a) BURIAL (b) Date thereof 3-8-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

18. (a) Signature of funeral director PALMER'S (b) Address LEBANON

19. (a) 3-7-41 (b) J. M. Curtis (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 6 year 1941 hour 11 minute P M.

21. I hereby certify that I attended the deceased from 10:50 P.M. 3/6, 1941, to 11 P.M. 3/6, 1941; that I last saw him alive on Mar, 6, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure! Duration 1 1/2 hrs.

Due to...

Due to... 936

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature James D. Hope (M. D. or other) Address Lebanon, Mo. Date signed 3/9/41

PHYSICIAN Underline the cause to which death should be charged statistically

2002

RECEIVED  
District Health Officer No. 7,  
District No. 1161  
Date Filed 11/16/11

**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 \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed *Robert Mui*  
Licensed Embalmer No. 1161  
P. O. Address *Lawrence Mui*

**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 this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11140

Registration District No. 449

Primary Registration District No. 5609

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Lebanon, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Robert Stewart Stratton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 83 Months 0 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 6  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him alive on Mar 6, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death cardiac failure Duration 2 hrs

Due to myocarditis, acute

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) None

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James L. Hope (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 6/8/41

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

1941

S-11140