

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27679
Registrar's No. _____

FILED SEP 10 1941

Registration District No. 19

Primary Registration District No. 4013 11

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison
(c) City or town Rock Port Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23
year 1941 hour 7 minute 10 M.
21. I hereby certify that I attended the deceased from Aug 16, 1941, to Aug 23, 1941;
that I last saw her alive on Aug 23, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to _____

Duration

10 days

5 yrs.

Other conditions
(Include pregnancy within 3 months of death)

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 [Signature] (M. D. or other) _____
Address Rock Port Mo Date signed 8-25-41

3. (a) PRINT FULL NAME Mary Elizabeth Strabel
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife J. C. Strabel 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased Aug 23 1941
(Month) (Day) (Year)

8. AGE: Years 82 Months 6 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Clarion County Pa.
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

MOTHER FATHER
12. Name John J. Strabel
13. Birthplace Madison Pa.
(City, town, or county) (State or foreign country)
14. Maiden name Mary
15. Birthplace Northumberland Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Missie J. Strabel
(b) Address Rock Port, Miss.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 1941
(Month) (Day) (Year)
(c) Place: burial or cremation Mount Hope Cemetery, Mount City, Mo.
18. (a) Signature of funeral director [Signature]
(b) Address Rock Port Mo.
19. (a) Sept 2 - 1941 (Date received local registrar) (b) Mary G. Chamberlain (Registrar's signature)

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.

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 By Me

..... Registered Apprentice No.

working under my personal supervision.

Signed

J. B. Bertram

Licensed Embalmer No. 4024

P. O. Address Rock Point

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.