

FILED NOV. 8 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. ~~337~~ 337

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Southeast Mo. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 hours
(Specify whether
In this community 11 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. 230 Mill Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Doyle F. Strauser

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Joe Davis 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 30th 1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 4 15 hr. min.

9. Birthplace Bloomfield Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Employed with Mo. Utilities

11. Industry or business No.

MOTHER FATHER { 12. Name Frank Strauser
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Nettie Rempley
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nettie Strauser
(b) Address Cape Girardeau, Missouri
17. (a) Burial (b) Date thereof 10-17-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Union Cemt. Swinton

18. (a) Signature of funeral director L.L. Haman
(b) Address Cape Girardeau, Missouri
19. (a) 10-22-1945 (b) L.C. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15th
year 1945 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Gumshot wound in head, two inches above right eye Duration _____
Due to Self inflicted wound from .22 Springfield rifle
Due to _____

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) Suicide
(b) Date of occurrence Oct. 15, 1945
(c) Where did injury occur? Cape Girardeau, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at his home - 230 Mill St.
While at work? no (Specify type of place) (e) Means of injury 22 Rifle

23. Signature Dr. J. F. Higgins (M.D. or D.O.)
Address Jackson, Mo. Date signed 10/19/45

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

16
1
4

RECEIVED

District Health Officer No. 4
District File Number 1145-1262
Date Filed 11-6-45

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
Lee Townes Registered Apprentice No. 376
working under my personal supervision.

Signed D. B. Hama

Licensed Embalmer No. 2863

P. O. Address Cape Girardeau, Missouri

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, fact should be so stated above.