

FILED FEB 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5365

Registrar's No. 41

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Maywood 0640	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hosp.		d. STREET ADDRESS (If rural, give location) /	
3. NAME OF DECEASED (Type or Print) a. (First) Linda Rose Stratton b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) February 4, 1951
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH September 26, 1950
9. AGE (In years last birthday) 4		10. KIND OF BUSINESS OR INDUSTRY XX	11. BIRTHPLACE (State or foreign country) Illinois
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX		10b. KIND OF BUSINESS OR INDUSTRY XX	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Elmer Lee Stratton		13b. MOTHER'S MAIDEN NAME Mather Marget Silves	14. NAME OF HUSBAND OR WIFE XX
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XX	17. INFORMANT'S SIGNATURE OR NAME Mrs. E. L. Stratton
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH 2 da ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Septicemia</u> 49 IX 2 da.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/2, 1951, to 2/4, 1951, that I last saw the deceased alive on 2/4, 1951, and that death occurred at 11 A.M., from the causes and on the date stated above.			
23a. SIGNATURE <u>J. H. Hill</u>		23b. ADDRESS Palmyra Mo.	
23c. DATE SIGNED 2/4/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/4/51	
24c. NAME OF CEMETERY OR CREMATORY Ewing Missouri		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 2-9-51		REGISTRAR'S SIGNATURE By W.C. Fisher Deputy	
25. FEDERAL DIRECTOR'S SIGNATURE W. C. Campbell		ADDRESS Hannibal Mo	

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

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RECEIVED FEB 16 1951
HEALTH DEPT.
DATE FILED FEB 17 1951

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.

Signed John S. Stand.

Signed _____
Student Embalmer

Licensed Embalmer No. 4050

P. O. Address Hannibal 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.