

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7468

State File No.

FILED APR 7 1952

BIRTH MO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>355</u>	
1. PLACE OF DEATH a. COUNTY <u>BUCHANAN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>DEKALB</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. Joseph</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>MAYSVILLE 0320</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>CATHERINE</u>			b. (Middle) _____			c. (Last) <u>STRONG</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>April 2, 1952</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	
8. DATE OF BIRTH <u>6-9-1875</u>		9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days <u>9 8</u>		IF UNDER 28 HRS. Hours Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George W. Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Sheppard</u>		14. NAME OF HUSBAND OR WIFE <u>DEAD JOHN STRONG.</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'S SIGNATURE OR NAME ADDRESS <u>Audra Williams, Maysville, Mo</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congruen of Small Intestine. Obstruction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Strangulated Incisional Hernia.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hernia.</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Congruen Small Intestine, Obstruction</u>				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)		21f. HOW DID INJURY OCCUR? <u>5613</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>3-31</u> , 1952, to <u>4-2</u> , 1952, that I last saw the deceased alive on <u>4-2</u> , 1952, and that death occurred at <u>2:50 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Louis Lee, M.D.</u>				23b. ADDRESS <u>823 FAARON - ST. JOSEPH, MO</u>		23c. DATE SIGNED <u>4-2-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4/2-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairport</u>		24d. LOCATION (City, town, or county) (State) <u>Fairport Mo</u>	
DATE REC'D BY LOCAL REG. <u>April 4, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pilcher Funeral Home</u>		ADDRESS <u>Maysville Mo.</u>	

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

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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.....



C.T. Pilcher

Signed.....
Student Embalmer

Licensed Embalmer No. **3960**

P. O. Address **Waysville No.**.....

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.