

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26121**

FILED AUG 27 1956

REG. DIST. NO. **42**

PRIMARY REG. DIST. NO. **1000**

Registrar's No. **893**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 893	
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Kansas b. COUNTY Doniphan			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 1 day		c. CITY OR TOWN Highland		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital				e. STREET ADDRESS (If rural, give location) 815 S			
3. NAME OF DECEASED (Type or Print) a. (First) EMMA		b. (Middle) KATHERINE		c. (Last) STRUNK		4. DATE OF DEATH (Month) (Day) (Year) August 12, 1956	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH July 20, 1876	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and State or Foreign Country) Hollis, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Phillip Newton			13b. MOTHER'S MAIDEN NAME Sarah M. Lear			14. NAME OF HUSBAND OR WIFE William M. Strunk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Carl Shonyo, Highland, Kansas			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Right Lower Lobe Pneumonia 84 hrs		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				" "	
DUE TO (b) Vomiting and Opereation		DUE TO (c) Insulin Shock				" "	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Diabetes Mellitus				years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min.)		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 August 11, 1956 to Aug 12, 1956 , that I last saw the deceased alive on Aug 12, 1956 and that death occurred at 12:45 a.m. , from the causes, and on the date stated above.							
23a. SIGNATURE (Degree or title) Caryle A. Totten, M.D.				23b. ADDRESS (City, town, or county) (State) Physicians & Surgeons 2232 Edgemoor Field Ave. St. Joseph, Mo. 8/18/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) removed		24b. DATE 8/12/1956		24c. NAME OF CEMETERY OR CREMATORY St. Joseph, Mo.		24d. LOCATION (City, town, or county) (State) Highland, Kansas	
DATE REC'D BY LOCAL REG. Aug 22, 1956		REGISTRAR'S SIGNATURE Cather M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Heaton-Bowman St. Joseph, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

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..

Student.....
Signature of Student Embalmer

Signed.....
William Spelling

Licensed Embalmer No. *4535*

P. O. Address *3145 10th St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.