

pt. Health,
, & Welfare
S. Public
alth Service

V. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36487

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 119

Primary Registration District No. 4259

Registrar's No. 63

1. PLACE OF DEATH a. COUNTY Knox		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Lewis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Newark		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Newark 05 1/2 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LUCIAN Middle C. Last STROCK			4. DATE OF DEATH Month Nov. Day 7 Year 1957		
--	--	--	---	--	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1867	9. AGE (In years last birthday) 90	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
-----------------	---------------------------	---	--	---	-----------------------------------	------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (City and state or country) Adair Co. Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	---

13a. FATHER'S NAME Myron STROCK	13b. MOTHER'S MAIDEN NAME Arvy Kelley	14. NAME OF HUSBAND OR WIFE
---	---	-----------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Orville F Strock, Newark Mo	Address
---	-------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour 4:30 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 493X	COUNTY	STATE
---	---	--	---	--------	-------

21. I attended the deceased from Nov 4 1957 to Nov 7 1957 and last saw ^{her} him alive on Nov 6 1957 Death occurred at 2:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) H. Emmeth Glover D.O.	22b. ADDRESS Newark Mo	22c. DATE SIGNED 11-7-57
--	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) NOV. 10 - 1957	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY J.O.O.F.	23d. LOCATION (City, town, or county) (State) Newark, Knox Co. Mo
--	-----------	---	---

24. FUNERAL DIRECTOR Thomas Ball Ewing Mo	ADDRESS 905 S. 57	25. DATE RECD. BY LOCAL REG. Nov 8 1957	26. REGISTRAR'S SIGNATURE Frank A. Hunsolt
---	-----------------------------	---	--

(License Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

510

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 *L. M. Crabell*

Licensed Embalmer No. *4905*

P. O. Address *Livingston Mo*

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.