

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013658  
STATE FILE NUMBER

FILED APR 25 1958

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 121

5. 300  
1-57

6

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>			
b. CITY OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>New Bloomfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hosp</u>			Length of stay in 1b <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>5 mi SE</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C.</u> Last <u>Straw</u>				4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16 1884</u>		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Callaway Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>Wesley Straw</u>			13b. MOTHER'S MAIDEN NAME <u>Chassie Sanders</u>		14. NAME OF <del>HUSBAND</del> OR WIFE <u>Tora Straw</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 <u>Reid Straw</u> Address <u>New Bloomfield Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Wk</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u>						<u>2 wks</u>	
DUE TO (c) <u>Arteriosclerotic heart disease</u>						<u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic hypertrophy</u>						19. WAS AUTOPSY PERFORMED? <u>2</u> 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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>							
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.) <u>R</u>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>April 12 1958</u> to <u>April 17</u> and last saw <sup>her</sup> him alive on <u>April 17/1958</u> Death occurred at <u>6:05 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William A. Cox M.D.</u>				22b. ADDRESS <u>Jefferson Co Mo</u>		22c. DATE SIGNED <u>April 19/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/20/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Middle River</u>		23d. LOCATION (City, town, or county) <u>Tebbetts</u>		STATE <u>MO.</u>
24. FUNERAL DIRECTOR <u>Claypool Fun. Home</u> ADDRESS <u>New Bloomfield Mo</u>			25. DATE RECD. BY LOCAL REG. <u>19 April 1958</u>		26. REGISTRAR'S SIGNATURE <u>R.P. Harris, M.D. - M.R.</u>		

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 *LeRoy Claypool* .....

Licensed Embalmer No. *4412* .....

P. O. Address *New Bloomfield* .....

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.