

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043175

STATE FILE NUMBER

FILED JAN 5 1958

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 274

300
-57

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico		c. CITY OR TOWN Benton City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Allen Nursing Home		d. STREET ADDRESS (If outside, give location) R.F.D.#1	
3. NAME OF DECEASED (Type or print) First Samuel Middle Edwards Last Stratton		4. DATE OF DEATH Month Dec. Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Lisle, Ill.
13a. FATHER'S NAME Samuel Fay Stratton		13b. MOTHER'S MAIDEN NAME Mary Goodrich	14. NAME OF HUSBAND OR WIFE Hattie Stratton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Walter Stratton Address Benton City, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Long standing arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Genital impotency due to age.			INTERVAL BETWEEN ONSET AND DEATH 18 hrs 15 yrs
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.) 332x	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 COUNTY STATE
21. I attended the deceased from 1948 to 12-22-58 and last saw him alive on Dec 14, 1958 Death occurred at 5:45 AM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W. K. Kellenbach M.D.		22b. ADDRESS Mexico, Mo.	22c. DATE SIGNED Dec 22, 1958
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 26, 1958	23c. NAME OF CEMETERY OR CREMATORY East Lawn	23d. LOCATION (City, town, or county) (State) Mexico, Mo.
24. FUNERAL DIRECTOR ADDRESS Precht-Hueston Mexico, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 26-1958	26. REGISTRAR'S SIGNATURE Blanche Neely

MEDICAL CERTIFICATION
All diseases in Part I must be causally related.
S. P. HALL, Embalmer, Mexico, Mo.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JAN 23 1959

JAN 22 1959

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 *Robert P. Keeton*

Licensed Embalmer No. 4687.....

P. O. Address...Mexico, 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.