

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000742
STATE FILE NUMBER

FILED JAN 8 1959 Registration District No. JK Primary Registration District No. 5329 Registrar's No. 1-1959

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OAKHILL TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cuba</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home - Argo Rd.</u>		Length of stay in lb <u>2 Years</u>	d. STREET ADDRESS (If outside, give location) <u>Route # 2</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Elizabeth STRaub</u>			4. DATE OF DEATH Month Day Year <u>JAN. 2 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22 1887</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Jacob STRaub</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
14. NAME OF HUSBAND OR WIFE <u>Never married</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>490-36-3117A</u>
17. INFORMANT Address <u>Raymond G. Hall RT 2 Cuba 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>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Old Cerebro-vascular accident</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>years</u>		19. WAS AUTOPSY PERFORMED? 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 <u>9-21-58</u> to <u>1-1-59</u> and last saw her/him alive on <u>1-1-59</u> Death occurred at <u>2:55P</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ronald Van Arsdell, M.D.</u>		22b. ADDRESS <u>Bourbon, Mo.</u>	
22c. DATE SIGNED <u>4 Jan 59</u>		22d. DATE SIGNED (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-5-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City, town, or county) (State) <u>Cuba mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>No-Nor Funeral Home Cuba, mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan. 4, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Paul G. Shanthin</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Norman V. Hoene*

Licensed Embalmer No. *4673*

P. O. Address *Cuba, M.*

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.