

Health,
Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013566

STATE FILE NUMBER 1680

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in lb 30 years	d. STREET ADDRESS (If outside, give location) 3710 BALTIMORE AVE.

3. NAME OF DECEASED (Type or print) First Middle Last HOWARD LESLIE STROTHER			4. DATE OF DEATH Month Day Year MARCH 30, 1959		
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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 10-14-07	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY SPRAY & ELECTRIC	11. BIRTHPLACE (City and state or country) BRUNSWICK, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME WILLIAM STROTHER	13b. MOTHER'S MAIDEN NAME EVA LEWELLEN	14. NAME OF HUSBAND OR WIFE ALICE STROTHER
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II WW II	16. SOCIAL SECURITY NO. 486-10-1087	17. INFORMANT Official Records VA Hospital, K.C., Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventilatory Insufficiency		INTERVAL BETWEEN ONSET AND DEATH,
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? 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.)
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20c. TIME OF INJURY Hour 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 COUNTY STATE
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21. Was attended the deceased from Death occurred on 3-29-59 to 3-30-59 and last saw him alive of 7:35 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) WALTER W. HAIR, M.D.	22b. ADDRESS VA Hospital K.C., Mo	22c. DATE SIGNED 3-30-59
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE Apr. 2, 1959	23c. NAME OF CEMETERY OF COUNTY (State) Ebenezer Cemetery 10 MILES (EAST OF) St. Joseph Missouri
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, K.C. Missouri	25. DATE RECD. BY LOCAL REG. 4-2-59	26. REGISTRAR'S SIGNATURE New Marshall
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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

Licensed Embalmer No.
P. O. Address

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.