

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031701

FILED VS SEP 28 1959

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3010

336

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>			2. USUAL RESIDENCE (Where deceased lived ^{at the time of death} before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Length of stay in 1b <u>2 Wks</u>	c. CITY OR TOWN <u>Zalma</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cape Osteopathic</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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 <u>Ida</u> Middle <u>May</u> Last <u>Strong</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</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>2-2-1895</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (City and state or country) <u>Stanton, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>W^m Bess</u>		13b. MOTHER'S MAIDEN NAME <u>Cindy De Shazer</u>	
14. NAME OF HUSBAND OR WIFE <u>J. H. Strong</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>J. H. Strong - Zalma, 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>Acute cardiac decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Advanced arteriosclerosis</u>		DUE TO (c) _____		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Ventral hernia, operated</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. Month, Day, Year _____		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>9/2/59</u> to <u>9/16/59</u> and last saw ^{her} him alive on <u>9/15/59</u> Death occurred at <u>8:10 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Rosa B Thompson D.O.</u>			22b. ADDRESS <u>105 So. Spanish, Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>9/21/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brownwood</u>		23d. LOCATION (City, town, or county) (State) <u>Brownwood, Mo.</u>	
24. FUNERAL DIRECTOR <u>W^m H. May</u> ADDRESS <u>Adrian, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>9-22-1959</u>		26. REGISTRAR'S SIGNATURE <u>Ferne Kasten</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W^m H. Morgan

Licensed Embalmer No.

P. O. Address Advance

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.