URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

59-036654
STATE FILE NUMBER

MENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 192

1. PLACE OF DEATH
a. COUNTY: Jasper
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Carthage — Length of stay in 1b: 37 yrs.
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 923 Orner St. — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jasper
c. CITY OR TOWN: Carthage, — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 514 Miller St. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Albert Middle: Last: Straine
4. DATE OF DEATH: Month October Day 11 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-19-82
9. AGE (last birthday): 77
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd. Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (City and state or country): Eureka Springs, Ark.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: John Straine
13b. MOTHER'S MAIDEN NAME: Nancy P. Hicks
14. NAME OF HUSBAND OR WIFE: Rose Heisten Straine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 490-10-2220
17. INFORMANT: Nellie Ahrens — Address: Carthage Rt. # 4

MEDICAL CERTIFICATION

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 — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — Unknown.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-29-56 to 10-11-59 and last saw ~~her~~ him alive on 10-10-59
Death occurred at 2:55 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Grover S. Patterson (Degree or title) M.D.
22b. ADDRESS: Carthage, Missouri
22c. DATE SIGNED: 10-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-14-59
23c. NAME OF CEMETERY OR CREMATORY: Park Cemetery
23d. LOCATION (City, town, or county) (State): Carthage, Mo.
24. FUNERAL DIRECTOR: Ulmer Funeral Home — ADDRESS: Carthage, Mo.
25. DATE RECD. BY LOCAL REG.: 10-13-59
26. REGISTRAR'S SIGNATURE: Elf Clinton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4955

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl 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.