

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 5 0 7

REGISTRATION DISTRICT NO. 43 PRIMARY REGISTRATION DISTRICT NO. 3007 REGISTRAR'S NO. 629 STATE FILE NUMBER

UNRECORDED

FILED VS JAN 11 1960

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY WAYNE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 10 DAYS	c. CITY OR TOWN WILLIAMSVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		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 checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First NATHANIEL Middle WILSON Last STRICKLAND			4. DATE OF DEATH Month DECEMBER Day 20 Year 1959			
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 9-9-94	9. AGE (last birthday) 65	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) Timber Dealer		10b. KIND OF BUSINESS OR INDUSTRY Timber		11. BIRTHPLACE (City and state or country) Chaonia, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Elsha Strickland		13b. MOTHER'S MAIDEN NAME Martha Wilson		14. NAME OF HUSBAND OR WIFE Jewell Strickland		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT VA Hospital Records	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:		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, LEFT.		UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CEREBRAL ARTERIOSCLEROSIS, CHRONIC.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE.	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 VA	COUNTY	STATE
21. I attended the deceased from December 10, 1959 to Dec. 20, 1959		Death occurred at 5:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE J. LESTER HARWELL, M.D., Actg. Pathologist VA Hospital, Poplar Bluff, Mo.	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED 12-20-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12-22-59	23c. NAME OF CEMETERY OR CREMATORY Holiday Cem.	23d. LOCATION (City, town, or county) Poplar Bluff, Mo.

24. FUNERAL DIRECTOR Frank-Cotrell Poplar Bluff, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 1/28/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7006

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EX-100
1980

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 Edgar W. Taylor

Licensed Embalmer No. 3394

P. O. Address Poplar Bl

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.