

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

'59 0 4 4 0 4 9

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 8

ENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>HOWELL</u>		a. STATE <u>MISSOURI</u>		b. COUNTY <u>HOWELL</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS,</u>		Length of stay in 1b <u>4 yrs.,</u>		c. CITY OR TOWN <u>WEST PLAINS,</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>202 E. SECOND</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>11 11 E. SECOND</u>	
				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>WILLIAM TAYLOR STRONG</u>			4. DATE OF DEATH <u>12-28-59</u>		
First Middle Last			Month Day Year		

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>12-24-74</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------	----------------------------------	-------------------------------------------	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u> <u>X</u>	11. BIRTHPLACE (City and state or country) <u>OSARK CO., MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
--------------------------------------------------------------------------------------------------------------	--------------------------------------------------------	--------------------------------------------------------------------------	---------------------------------------------

13a. FATHER'S NAME <u>JAMES STRONG</u>	13b. MOTHER'S MAIDEN NAME <u>? UPTON</u>	14. NAME OF HUSBAND OR WIFE <u>FANNIE STRONG</u>
-------------------------------------------	---------------------------------------------	-----------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT <u>ARTHUR STRONG, WEST PLAINS, MO</u> Address
-------------------------------------------------------------------------------------------------------	-------------------------------------------------------------	----------------------------------------------------------------

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 <u>30 Min.</u>
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>		
DUE TO (b) <u>Arteriosclerotic Heart Dis.</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis generalized</u>		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

19. WAS AUTOPSY PERFORMED? YES <input 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.) <u>_____</u>
----------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year <u>_____</u>
---------------------------------------------------------------	----------------------------------

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.) <u>_____</u>	20f. CITY, TOWN, OR LOCATION <u>_____</u>	COUNTY <u>_____</u>	STATE <u>_____</u>
--------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------	----------------------------------------------	------------------------	-----------------------

21. I attended the deceased from 12-28-59 to 12-28-59 and last saw him alive on 12-28-59  
Death occurred at 6:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Legible or scribe) <u>Joseph N. Wilke M.D.</u>	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>1-3-60</u>
-------------------------------------------------------------------	----------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>_____</u>	23b. DATE <u>12-30-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PATRICK</u>	23d. LOCATION (City, town, or county) (State) <u>GAINSVILLE, MO</u>
-----------------------------------------------------------	------------------------------	------------------------------------------------------	------------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>ROBERTSONS, WEST PLAINS, MO</u>	25. DATE RECD. BY LOCAL REG. <u>1-6-60</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
------------------------------------------------------------	-----------------------------------------------	---------------------------------------------------

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 8 1960

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 J. J. Roberts

Licensed Embalmer No. 3437

P. O. Address West 7th

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.