

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-026054

STATE FILE NUMBER

FILED VS AUG 8 1960

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 439

1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CARTER</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>VAN BUREN 01502</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctors Hospital 2</u>		Length of stay in lb <u>6 days</u>		d. STREET ADDRESS (If outside, give location) <u>VAN BUREN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>FRANKLIN</u> Last <u>STRONG</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>MALE</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>FEB 14 1889</u>	9. AGE (In years last birthday) <u>71</u>	10. UNDER 1 YEAR Months <u>5</u> Days	11. UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Wayne County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Richard Strong</u>			13b. MOTHER'S MAIDEN NAME <u>MARGARET ENGLAND</u>		14. NAME OF HUSBAND OR WIFE <u>OSA 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.	17. INFORMANT Address <u>OSA Strong - Van Buren, 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>Malignant hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Renal failure</u>		DUE TO (c) <u>445</u>				unknown	
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.)							
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>July 8, 1960</u> to <u>July 19, 1960</u> and last saw <u>him</u> alive on <u>July 13, 1960</u> Death occurred at <u>12:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Name or title) <u>Robert C. Chynoweth M.D.</u>				22b. ADDRESS <u>Poplar Bluff, Mo</u>		22c. DATE SIGNED <u>7-21-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7-17-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>		23d. LOCATION (City, town, or county) <u>Van Buren, Mo.</u>		(State)			
24. FUNERAL DIRECTOR <u>McSpadden</u>		ADDRESS <u>Van Buren Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7/25/60</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>				

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 Ronald B. Sloan, Student Embalmer No. 606 working under my personal supervision.

Student Ronald B. Sloan  
Signature of Student Embalmer

Signed Allen C. McFadden

Licensed Embalmer No. 4543

P. O. Address Van Buren, W

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.