RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-043120

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 148

DED

1. PLACE OF DEATH
a. COUNTY Pulaski

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pulaski

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville — Length of stay in 1b: 1 day

c. CITY OR TOWN Waynesville — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) General Hospital — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Linda — Middle Marie — Last Stroyick

4. DATE OF DEATH: Month November — Day 2 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Widowed ☐ Never Married ☒ Divorced ☐

8. DATE OF BIRTH: 10-31-60

9. AGE (last birthday) — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HR: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): X

10b. KIND OF BUSINESS OR INDUSTRY: X

11. BIRTHPLACE (City and state or country): Waynesville, Mo.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Bill Stroyick

13b. MOTHER'S MAIDEN NAME: Alice Volmert

14. NAME OF HUSBAND OR WIFE:

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.: X

17. INFORMANT: Bill Stroyick — Address: Iberia, Mo.

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 Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 40 hrs

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Prolong, Difficult Labor

DUE TO (c) Cephalo-Pelvic dysproportion

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 Oct 31, 1960 to Nov. 2, 1960 and last saw her alive on Nov 1, 1960

Death occurred at 3:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John A. Mihalevich D.O.

22b. ADDRESS: Crocker, Mo

22c. DATE SIGNED: 11-2-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11-3-1960

23c. NAME OF CEMETERY OR CREMATORY: St. Anthony Cemetery

23d. LOCATION (City, town, or county) (State): St. Anthony, Missouri

24. FUNERAL DIRECTOR: Humphrey Funeral Home — ADDRESS: Iberia, Mo.

25. DATE RECD. BY LOCAL REG.: 11-3-60

26. REGISTRAR'S SIGNATURE: Eula Mae Anderson

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed J. A. Humphrey
Signature of Student Embalmer

Licensed Embalmer No. 4772

P. O. Address Shelia, Mo

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