SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-037689
STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 169

FILED NOV 3 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon — Length of stay in 1b 8 Hrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Taylor Rest Home — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Macon
c. CITY OR TOWN Callao Mo — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Edward Middle Last Stroud
4. DATE OF DEATH Month 10 Day 11 Year 61
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5-15-83
9. AGE (last birthday) 78 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (City and state or country) Yates City Ill
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Benjamin Stroud
13b. MOTHER'S MAIDEN NAME Henryetta Kindle
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.
17. INFORMANT Mrs. Frank Pillers Address Callao

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	Acute myocardial failure	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral vascular accident	2 days
DUE TO (c)	Diabetis mellibus with acidosis	several weeks

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 1949 to 1961 and last saw her/him alive on 10-10-61
Death occurred at 5:50 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Sabrey L. Carden D.O.
22b. ADDRESS Macon, Missouri
22c. DATE SIGNED 10-21,61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-14-61
23c. NAME OF CEMETERY OR CREMATORY Rose Cemetery
23d. LOCATION (City, town, or county) Callao (State) Mo

24. FUNERAL DIRECTOR H. G. Edwards ADDRESS Bowen
25. DATE RECD. BY LOCAL REG. 10/26/61
26. REGISTRAR'S SIGNATURE Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

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 [illegible]

Licensed Embalmer No. 1961

P. O. Address Bevier Mo

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.