

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007840

STATE FILE NUMBER

Registration District No. 23-7 Primary Registration District No. 4391 Registrar's No. 8

FILED MAR 14 1963

DO NOT WRITE ON THIS STUB AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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11	
12	90-0
13	2-0

1. PLACE OF DEATH a. COUNTY Osage		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Osage	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Meta		Length of stay in 1b Life	c. CITY OR TOWN Meta Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Residence Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HERMAN Middle H. Last STROP			4. DATE OF DEATH Month March Day 10 Year 1963
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 8-24-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY St. Thomas, Mo.	9. AGE (last birthday) 80
13a. FATHER'S NAME Bernard Strop		13b. MOTHER'S MAIDEN NAME Catherine Gerling	14. NAME OF HUSBAND OR WIFE Catherine Strop
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Catherine Strop Meta, Mo.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Arteriosclerosis generalized DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH years
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. <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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ 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 COUNTY STATE	
21. I attended the deceased from Jan 2/63 to Mar 19/63 and last saw him alive on 3-2-63 Death occurred at 6:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Ronan A. Taylor M.D.		22b. ADDRESS Jefferson City	22c. DATE SIGNED 3-12-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-13-1963	23c. NAME OF CEMETERY OR CREMATOR St. Cecilia Cemetery
24. FUNERAL DIRECTOR Scrivner-Stevinson		23d. LOCATION (City, town, or county) Meta, Missouri	
25. DATE RECD. BY LOCAL REG. 3-13-1963		26. REGISTRAR'S SIGNATURE Miss Clyde Norton	

MAR 19 1963

1963

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 Jay L. Stevenson
Licensed Embalmer No. 5201

P. O. Address Iberia, 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.