

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033141

STATE FILE NUMBER

Registration District No. 374 Primary Registration District No. 3052 Registrar's No. 292

FILED AUG 29 1963

DO NOT WRITE ON THIS STUD

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>		Length of stay in lb <u>22 yrs.</u>	c. CITY OR TOWN <u>SEDALIA</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>Bothwell Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1319 So. Kentucky</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clotilde STRAKA</u>		4. DATE OF DEATH Month Day Year <u>Aug. 23 1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Morgan Co. Mo</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>79</u> Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Peter C. Rippel</u>		13b. MOTHER'S MAIDEN NAME <u>Theresa Belfay</u>	14. NAME OF HUSBAND OR WIFE <u>John Straka</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. <u>11</u>	17. INFORMANT <u>John J. Straka - 906 So. Mo. Ave</u> Address
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensating Heart.</u> DUE TO (b) <u>Adenocarcinoma of st. Breast</u> DUE TO (c) <u>metastases both lungs, axillary nodes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>lymph</u> <u>metastases both lungs, axillary nodes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>2 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 checked="" 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>8/21/62</u> to <u>8/23/62</u> and last saw her alive on <u>8/23/63</u> Death occurred at <u>2:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H. J. Holden M.D.</u>		22b. ADDRESS <u>1116 W 3rd Sedalia Mo</u>	22c. DATE SIGNED <u>8/26/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-26-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul</u>	23d. LOCATION (city, town, or county) (State) <u>Coll Camp, Mo</u>
24. FUNERAL DIRECTOR <u>McLAUGH LIN BROS. SEDALIA Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 26, '63</u>	26. REGISTRAR'S SIGNATURE <u>Francis Anderson</u>

1708

**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 K. P. McEary

Licensed Embalmer No. 31530

P. O. Address Sedalia 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.