

Dr. ~~XXXXXXXXXX~~
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043596

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 125 Primary Registration District No. 2000 Registrar's No. 1744

DO NOT WRITE ON THIS STUB

AMENDED

FILED DEC 16 1963

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
Length of stay in 1b 11 YRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1126 S. HILLCREST		d. STREET ADDRESS (If outside, give location) 1126 S. HILLCREST	
3. NAME OF DECEASED (Type or print) First CHRISTINE Middle STRODER Last STRODER		4. DATE OF DEATH Month DEC. Day 7 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/27/98
9. AGE (last birthday) 65		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) HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MT. GROVE, MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME GUNMAN TAYLOE	
13b. MOTHER'S MAIDEN NAME JOSIE WEST		14. NAME OF HUSBAND OR WIFE THOMAS J. STRODER (DEC)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS. HELEN SPIRES, KANSAS CITY, MO.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed to be Natural Causes			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			UNATTENDED BY: PHYSICIAN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to terminal disease condition given in PART I (a)			
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		According to neighbors saw patient around 6:30 a.m. About 11:30 found patient dead.	
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 _____ and last saw him alive on _____ Death occurred at Approx. 11:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Dr. R. Donohy, Health Officer		22b. ADDRESS Springfield, Mo.	
22c. DATE SIGNED		22d. LOCATION (City, town, or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12-10-63	
23c. NAME OF CEMETERY OR CREMATORY GREENLAWN		23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.	
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 12-12-63	
26. REGISTRAR'S SIGNATURE James Medley			

VS 300 Rev. 4/59
 10397
 20397
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

EMBALMER - STATE

MISSISSIPPI

12-9-63
11:00
11:00

STATEMENT BY LICENSED EMBALMER

2-2

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 Terrence T. Swally

Licensed Embalmer No. 4875

P. O. Address Springfield, 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.