

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County AtchisonTownship Clark

or

Village

or

City

Registration District No. 17File No. 2930349Primary Registration District No. 502Registered No. 147

(NO. _____) St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Francis Stewart Strickler

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Nov 24th, 1914</u> (Month) (Day) (Year)		AGE <u>1</u> yrs. <u>11</u> mos. <u>20</u> ds.
OCCUPATION (a) Trade, profession, or particular kind of work		If LESS than 1 day, ___ hrs., or ___ min.?
(b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE
(City or town, State or foreign country) Gray Mo.

NAME OF FATHER Thomas Strickler

BIRTHPLACE OF FATHER
(City or town, State or foreign country) Atchison Co. Mo.

MAIDEN NAME OF MOTHER Della Stovall

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Mann

(ADDRESS) Gray Mo.

Filed Sept 15, 1916 J. W. Blevins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 14, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 11th, 1916, to Sept 14th, 1916, that I last saw him alive on Sept 17, 1916, and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:
Acute Enterocolitis

1198 104

(Duration) ___ yrs. ___ mos. 5 ds.

Contributory (SECONDARY) _____
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. C. Ottum M. D.
Sept 14, 1916 (Address) Gray Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted
If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Thorp Cemetery

DATE OF BURIAL Sept 15, 1916

UNDERTAKER _____

ADDRESS _____

of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

WALIE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

v. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH
County Atchison
Township Clark
or
Village
or
City (NO. St. Ward)
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW
Registration District No. 17 File No. 29
Primary Registration District No. 5021 Registered No. 147

2 FULL NAME Francis Stewart Strubler
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) S.

6 DATE OF BIRTH
(Month) (Day) (Year)

7 AGE
If LESS than 1 day.....hrs. or.....min.?
.....yrs.....mos.....da.

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15 Filed Sept 15 1916 J. M. Blevins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
(Month) (Day) (Year)
Sept. 14 1916

17 I HEREBY CERTIFY, that I attended deceased from 1916 to 1916
that I last saw him alive on 1916
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)
(Duration) mos. ds.
(Signed) M. D.
(Address) 1916

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Satisfactory Information Supplied DATE OF BURIAL 1916

20 UNDERTAKER C. W. David ADDRESS Kearney St

Original file, date..... SEP 1916

All information called for must be written on this Supplementary Certificate.

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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