

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

Do not use this space.

1. PLACE OF DEATH **DEC 17, 1934**  
 County **Adair** Registration District No. **2/5002**  
 Township **Winnemah** Primary Registration District No. **6-B-2**  
 City \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 File No. **38370**  
 Registered No. **27**

2. FULL NAME **John R Strickland**  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **M** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**  
 (write the word)  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Bell Strickland**  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 19, 1855**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
**78 6 22**  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **Coal miner**  
 (b) General nature of industry, business, or establishment in which employed (or employer) **Blind for 25 yrs.**  
 (c) Name of employer \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 11** 19**34**  
 17. I HEREBY CERTIFY, That I attended deceased from **Nov 6**, 19**34**, to **Nov 11**, 19**34**, that I last saw him alive on **Nov 6**, 19**34**, and that death occurred, on the date stated above, at **10 P.** m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Hemiplegia**  
**13 1/2** (duration) yrs. mos. **6** ds.  
 CONTRIBUTORY **chronic interstitial nephritis**  
 (SECONDARY) (duration) **7** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **at home**  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? **No** DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? **No**  
 WHAT TEST CONFIRMED DIAGNOSIS **clinical**  
 (Signed) **J. S. Haskewiler**, M. D.  
**11/12, 1934** (Address) **260 Younger Mo**

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) **Ill.**  
 (STATE OR COUNTRY)  
 10. NAME OF FATHER **John Strickland**  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ill.**  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER **Don't know**  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Don't know**  
 (STATE OR COUNTRY)

14. INFORMANT **S. J. Hill**  
 (Address) **R. F. D. Younger Mo.**

15. FILED **11/12 1934** **R. S. Gashwiler** REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Stone Point Cemetery** DATE OF BURIAL **11/12 1934**  
 20. UNDERTAKER **Llewellyn & Sons** ADDRESS **Younger**

N. 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.

