

REC'D MAY 24 1939

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

16443  
Do not use this space.

1. PLACE OF DEATH

(a) County Wright Registration District No. 908  
 (b) Township Mtn Grove Primary Registration District No. 4549 Registered No. 9  
 (c) City Mtn Grove (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 4 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

362 Emery Glenn Strickland  
 (a) Residence, No. Mountain Grove, Missouri (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 25, 1922  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
16 11 25  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Student  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 19, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1939, to Feb. 19, 1939  
 I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 3:30 A.M.  
 The principal cause of death and related causes of importance were as follows:

Pertussis caused by Typhoid  
 Date of onset 2/6/39

Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) W.A. Craig X D.  
Mountain Grove Mo. (Address)

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 FATHER 13. NAME Larry D. Strickland  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 MOTHER 15. MAIDEN NAME Elsie Phillips  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 17. INFORMANT Larry D. Strickland  
 (ADDRESS) Mtn Grove, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Knobnoster Mo. DATE Feb. 21, 1939  
 19. FUNERAL DIRECTOR (NAME) George Stapp  
 (ADDRESS) Mountain Grove Mo.  
 20. FILED 4-8-1939 Genevieve Montgomery Local Registrar

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.

RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1038

Date Filed MAY 8 1939

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, .....

George Stauff, or by .....

Registered Apprentice No. ...., working under my personal supervision

Signed George Stauff

Licensed Embalmer No. 3161

P. O. Address .....

**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 this body is not embalmed, above space should be left blank.**