DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6263

Registration District No. 165 (FEB 11 1940)

Primary Registration District No. 5930

Registrar's No. 14

1. PLACE OF DEATH:

(a) County: Cedar

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Cedar

(c) City or town: Humansville (Rural) (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years

3. (a) PRINT FULL NAME: JOSEPH HENRY STRANGE

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Victoria L. Strange

6. (c) Age of husband or wife if alive: 66 years

7. Birth date of deceased: May (Month) 30 (Day) 1873 (Year)

8. AGE: Years 66 Months 8 Days 7 If less than one day hr. min.

9. Birthplace: (City, town, or county) MO (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

FATHER 12. Name: Albert L. Strange

FATHER 13. Birthplace: (City, town, or county) MO (State or foreign country)

MOTHER 14. Maiden name: Adelia Casey

MOTHER 15. Birthplace: (City, town, or county) MO (State or foreign country)

16. (a) Informant's own signature: Joey Strange

(b) Address: Humansville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 7 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Elder Cemetery

18. (a) Signature of funeral director: Joseph Funeral

(b) Address: Humansville Mo

19. (a) Feb 13 1940 (Date received local registrar) (b) Mrs Minnie Barleton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 6 day Feb year 1940 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from Jan 17, 1940, to Feb 6, 1940, that I last saw him alive on Feb 6, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Paralysis	3 wks
Due to: Hemorrhage	
Hematemesis	18 hrs
Due to: Probable clot in vessel in wall of stomach	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Roscoe C. Newins (M. D. or other)

Address: Humansville Mo Date signed 2-6-40

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-5-17-39 Rev. 5-17-39 Form 1 X19511

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITIN[illegible] comply with the above constitutes grounds for revocation of license.)

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