

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11274

State File No. _____

Registration District No. 408

Primary Registration District No. 3020

Registrar's No. 58

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Carthage Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: M^cCune Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days (Specify whether
In this community 32 years
years, months or days) 0 0 1

3. (a) PRINT FULL NAME Martha Jane Strider
(b) If veteran, name war no
(c) Social Security No. no

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Marion Thomas Strider 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased May 23 1860
(Month) (Day) (Year) 59

8. AGE: Years Months Days If less than one day
80 9 12 hr. min.

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

10. Usual occupation Housekeeping

11. Industry or business General house work

12. Name William Thomas Jones

13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Martha Jones

15. Birthplace Dade Co. Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Frank Strider

(b) Address Carthage Mo

17. (a) Burial (b) Date thereof Mar 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashtroff Cem

18. (a) Signature of funeral director Chas J Teiler

(b) Address Jasper Missouri

19. (a) Mar 6 1940 (b) E. J. McDaniel, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jasper
(c) City or town Carthage Mo Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 2 1/4 mi South of Jasper
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1940 hour 11 minute 20 p.m.

21. I hereby certify that I attended the deceased from Feb. 20
1940 to Mar. 5 1940;
that I last saw h. in alive on Mar. 5 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal bronchopneumonia Duration 12 days

Due to Subtrochanteric fracture of left femur 15 days

Due to _____
Other conditions Acute and chronic ?
(Include pregnancy within 3 months of death)
gonorrheal nephritis

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

23. Signature Charles J. Schell, Jr. (M. D. or other) M.D.

Address Jasper Mo Date signed 3/6/40

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

19
5
2

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 440-1182

Date Filed APR 15 1940

19412-
99

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

Chas J. Teeter

....., Registered Apprentice No.

working under my personal supervision.

Signed

Chas J. Teeter

Licensed Embalmer No. 2566

P. O. Address Jasper 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18274**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **408**

Primary Registration District No. **3020**

Registrar's No. **58**

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

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Carthage**
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Martha June Grider**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 9 17 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

LEGAL CERTIFICATION

20. DATE OF DEATH Month **mar** day **5**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Broncho pneumonia**
subtrochanteric fracture of left femur
Due to **18/18**

Other conditions **acute or chronic glomerular nephritis**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: _____

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) **fall on kitchen floor**
(b) Date of occurrence **Feb 20, 1940**
(c) Where did injury occur? **2 mi. S. of Jasper, Mo.**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
landscaping covered kitchen floor
While at work? **no** (Specify type of place) (e) Means of injury _____

23. Signature **Chas H. Isbell** (M. D. or other) **M.D.**
Address **Jasper Mo.** Date signed _____

SUPPLEMENTAL

1940

S-11274