

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 28479

Registration District No. 309

Primary Registration District No. 4185

Registrar's No. 31

AUG 19 1940  
CALLED SEP 18 1940

1. PLACE OF DEATH:

(a) County Gentry  
(b) City or town Albany  
(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) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Leo Clayton Strohl 264

3. (b) If veteran, name war World War 3. (c) Social Security No. 1

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clara Noland 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased February 23rd 1891  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
49 6 16 hr. min.

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

10. Usual occupation Depot agent

11. Industry or business \_\_\_\_\_

12. Name Henry Strohl 6

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

14. Maiden name Elizabeth Schriener

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

16. (a) Informant Mrs. Leo Strohl  
(b) Address Albany, Missouri

17. (a) Burial (b) Date thereof Sept. 11-4  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Cemetery

18. (a) Signature of funeral director Edward Brock  
(b) Address Albany, Mo.

19. (a) Sept. 11, 1940 (Date received local registrar) W. T. Martin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry  
(c) City or town Albany  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9  
year 40 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-4-1940 to 9-9-1940;  
that I last saw him alive on 9-9-1940  
and that death occurred on the date and hour stated above.

Immediate cause of death "Mural Thrombosis" 7 da  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1070  
(Include pregnancy within 5 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) \_\_\_\_\_

(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Frank N. Rose (M. D. or other) M.D.

Address Albany, Mo Date signed 9-9-40

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

JAN 12 1948

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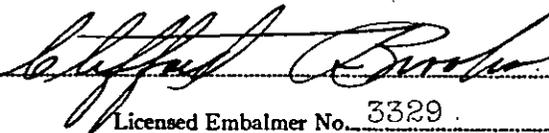
**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

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

working under my personal supervision.

Signed



Licensed Embalmer No. 3329

P. O. Address Albany, 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.