

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6313

State File No. _____

X26390

FILED MAR 19 1948 4

Primary Registration District No. 4110

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Christian
(b) City or town Cook Mo. Wn.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Almshouse
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 (Specify whether years, months or days)
In this community 15 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian
(c) City or town Cook Mo. Wn.
(If outside city or town limits, write "RURAL")
(d) Street No. None (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John W. Strickland

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

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

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

7. Birth date of deceased March 1 1858
(Month) (Day) (Year)

8. AGE: Years 83 Months 10 Days 7 If less than one day hr. _____ min.

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

10. Usual occupation labor

11. Industry or business _____

12. Name Don't know

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Stones Bidgen

(b) Address Cook Mo.

17. (a) Buried (b) Date thereof Jan 5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cook County

18. (a) Signature of funeral director G. B. Chaffin

(b) Address Cook Mo.

19. (a) Jan 21, 1948 (b) Booth Leonard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 7
year 1948 hour 7 minute 40 P.

21. I hereby certify that I attended the deceased from Jan 5 1948 to Jan 7 1948
that I last saw him alive on Jan 7 1948
and that death occurred on the date and hour stated above.

Immediate cause of death hemipia ✓ Duration 10 days

Due to _____

Due to _____

Other conditions (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) _____

(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 J. H. Hadd (M. D. or other) _____

Address Cook Mo. Date signed 1-21-48

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

RECEIVED

District Health Officer No. 6,

District File Number 342-402

Date Filed MAR 17 1942

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, 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, fact should be so stated above.

Registration District No. **184**

Primary Registration District No. **4110**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Christian**
(b) City or town **Rural**
(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)

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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **John W Strickland**
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month..... day.....
year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
that I last saw him/her alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **w**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **mas** (Month) (Day) (Year)

Leukemia
Due to **chronic nephritis**
Due to.....
Other conditions (include pregnancy within 3 months of death).....

8. AGE: Years **83** Months **10** Days..... If less than one day..... min.
9. Birthplace..... (City, town, or county) (State or foreign country)

Major findings:
Of operations.....
Of autopsy.....

10. Usual occupation.....
11. Industry or business.....
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)

1318
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant..... (b) Address.....
17. (a)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation.....
18. (a) Signature of funeral director..... (b) Address.....
19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

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..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

