

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 26 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1810 Kensington St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jacob M. Strickler

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Cora Strickler 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased June 4 1858
(Month) (Day) (Year)

8. AGE: Years 84 Months 0 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Druggist
Same

11. Industry or business retired

12. Name Henry Strickler

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

14. Maiden name Meriel Miller

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

16. (a) Informant Mrs. Cora Strickler
(b) Address 1810 Kensington St.

17. (a) Burial (b) Date thereof 6/17/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah
18. (a) Signature of funeral director Rose & Henderson
(b) Address 15th & Jackson St.

19. (a) 6-16-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
year 1942 hour 6:15 minute A. M.

21. I hereby certify that I attended the deceased from June 7-
1942 to June 15, 1942
that I last saw him alive on June 7, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia
Duration 5 days

Due to Chronic myocarditis

Due to 93 B

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 MR Foster M.D. (M. D. or other)
Address 1529 Sutter Date signed June 15

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

MOTHER FATHER

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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.....

....., 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 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.