DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3189

Registration District No. 293 | Primary Registration District No. 4436 | Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Ralls

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

(c) Name of hospital or institution: Residence
(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: Missouri (b) County: Ralls

(c) City or town: New London
(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: William C. Strode

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: Widowed

6. (b) Name of husband or wife: Edith Norton Strode

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

7. Birth date of deceased: February 22, 1871 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
70	10	22	..... hr. ..... min.

9. Birthplace: New London Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business .....

FATHER
12. Name: Samuel L. Strode
13. Birthplace: Ralls County Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Juliette Caldwell
15. Birthplace: Ralls County Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Miss Mamie Strode
(b) Address: New London Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/18/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Barkley Cemetery

18. (a) Signature of funeral director: Wm. M. Smith
(b) Address: 902 Broadway Hannibal Missouri

19. (a) 1-16-43 (Date received local registrar) (b) R S Barkley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14 year 1943 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1-5- 1943 to 1-14- 1943 that I last saw him alive on 1-12- 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart failure	
Due to: over exertion	
Due to: Arthritis Deformans	
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: H. J. Waters (M. D. ~~or other~~)
Address: New London Mo Date signed 1-16-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 1-43-163
Date Filed Jan-19-1943

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 Wm. M. Smith

Licensed Embalmer No. 1204

P. O. Address Hannibal Missouri

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.

No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2189

Registration District No. 293 Primary Registration District No. 4436 Registrar's No.

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town New London
(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 (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 Wm C. Strode
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 22 18 (Month) (Day) (Year)

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Heart Failure	
Myocarditis	
Due to over exertion	
Due to	
Other conditions arthritis deformans (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 93a

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

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

SUPPLEMENTARY