

FILED AUG 25 1943

State File No.

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 171

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Prison Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days in Hospital
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Delmar Strickland

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

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

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

7. Birth date of deceased: June 23rd., 1918
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 1 25 hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER { 12. Name Unknown
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 Prison Records.

(b) Address Jefferson City, Missouri

17. (a) Removal (b) Date there Aug 19-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Insiden, Mo.

18. (a) Signature of funeral director James Sewier

(b) Address 700 Jefferson

19. (a) 8-19-43 (b) J. H. Norman Richter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
(c) City or town Jefferson City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th
year 1943 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from 8-13 to 8-19
that I last saw him alive on 8-19 and that death occurred on the date and hour stated above.

Immediate cause of death Infection of jaw and neck
Extraction of tooth
following injury from fall

Other conditions Epilepsy
(Include pregnancy within 3 months of death)

Major findings: Of operations 1952

Of autopsy 1952

Duration 6 days

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 12/1
(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 fall

23. Signature W. H. ... (M. D. or other) 1943
Address 626 Jefferson Date signed 8-19-43

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

171
SEP 9 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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *F. C. Anderson*
Licensed Embalmer No. 3641
P. O. Address *Gene*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County Cole
(b) City or town S.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State Prison Hosp
(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 Delmar 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 S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 23
(Month) (Day) (Year)

8. AGE: Years 25 Months _____ Days _____ (Less than one day) min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August Day 18 Year 1943 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 Infection of jaw Duration _____
Extraction of tooth
following injury from
fall.
Due to Epilepsy

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: 186 a
Of operations _____
Of autopsy _____

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? Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fell on machinery
While at work? Yes (Specify type of place) (e) Means of injury Spinal
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

28052