

FILED JUL 7 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

21453
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 26
(b) Township N Benton Primary Registration District No. 5-347 Registered No. 107
(c) City Buffalo (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred 70 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOSEPH COPELAND STRICKLAND

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married!
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Myrtle
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 6 1873
7. AGE YEARS 70 MONTHS 6 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Dallas Co (STATE OR COUNTRY) Mo

FATHER 13. NAME George Strickland

14. BIRTHPLACE (CITY OR TOWN) Dallas Co (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Mary Jane Bach

16. BIRTHPLACE (CITY OR TOWN) Dallas Co (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Anna Myrtle Strickland
Buffalo Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Sweeney DATE June 1 1944

19. FUNERAL DIRECTOR (NAME) L B Jones (ADDRESS) Buffalo Mo

20. FILED 6-24-44 19 L B Jones Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 30 1944

22. I HEREBY CERTIFY, That I attended deceased from April 20 1944, to May 30 1944
Last saw her alive on May 29 1944. Death is said to have occurred on the date stated above, at 6 A.M.
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage

Date of onset 5-20-44

Other contributory causes of importance: Arteriosclerosis

Name of operation none Date of _____
What test confirmed diagnosis? Urinal Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) G. Blummer, M. D.
(Address) Buffalo Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1571

RECEIVED
District Health Officer No. 7:
District File Number 6-44-761
Date Filed 7-6-47

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 Leonard B. Jones

Licensed Embalmer No. 2598

P. O. Address Buffalo, N.Y.

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.