

FILED SEP 12 1945

State File No. ....

Registration District No. 316

Primary Registration District No. 4461

Registrar's No. 119

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Bismarck  
(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  
In this community life  
years, months or days) (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Bismarck  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME John Franklin Strickland

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 married

6. (b) Name of husband or wife Nettie Strickland 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased July 11th 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months 0 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation retired

11. Industry or business Rail road

12. Name Benjamin Strickland

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

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

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

16. (a) Informant Mrs. Nettie Strickland

(b) Address Bismarck Mo.

17. (a) burial (b) Date thereof 8-9-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bismarck Mo.

18. (a) Signature of funeral director White & Hill

(b) Address White Bismarck Mo.

19. (a) 8-13-45 (b) Ether Rudloff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6  
year 1945 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Jan 1 - 1945 to Aug 3 1945  
that I last saw him alive on Aug 2 and that death occurred on the date and hour stated above.

Immediate cause of death Rebreathal/Remarriage Duration \_\_\_\_\_

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 450  
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 Nas W. Zbuzman (M. D. or other) \_\_\_\_\_  
Address Bismarck Mo Date signed 8-9-45

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4  
District File Number 945-1100  
Date Filed 9-10-45

DEC 11 1953

DEC 11 1953

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 Rachel J. White  
Licensed Embalmer No. 3012  
P. O. Address Dorchester Mass.

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.