

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.

36580

**FILED DEC 4 1946**

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

37338  
**37763**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Miller Registration District No. 211  
 (b) Township Jan Henry Primary Registration District No. 5778  
 (c) City \_\_\_\_\_  
 (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 11-46 <sup>6</sup>

**2. PRINT FULL NAME**

Glenn Peter Danzert  
 (a) Residence, No. Miller Co Mo St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED? HUSBAND OF (OR) WIFE OF single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 38  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as saw mill, bank, etc. None  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/25, 1946  
 22. I HEREBY CERTIFY, That I attended deceased from 11/25, 1946 to 11/25, 1946  
 I last saw him alive on 11/25, 1946. Death is said to have occurred on the date stated above, at 1:15 A. M.  
 The principal cause of death and related causes of importance were as follows:  
Paralysis of Respiratory  
Center from  
diabetic fracture  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 16  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) Richard L. Wright, M. D.  
 (Address) Carrollton, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miller Co Mo  
 FATHER 13. NAME William Frank Strickoff  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miller Co Mo  
 MOTHER 15. MAIDEN NAME Jennie Ann Danzert  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miller Co Mo  
 17. INFORMANT (ADDRESS) R. G. Strickoff  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Home DATE 11/25, 1946  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Harvey W. Strickoff  
 20. FILED Nov 25, 1946 Miss Richard L. Wright Local Registrar

12-2-46

District File Number

District Health Officer No. 9,

RECEIVED

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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, above space should be left blank.**