

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED Aug 25 1947

Registration District No. **1947 3** Primary Registration District No. **5655** Registrar's No. **1216**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Mt. Vernon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **742 days**
(Specify whether
In this community **742 days**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri**
(b) County **Washington** **110**
(c) City or town **Mineral Point**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **0**
(If rural, give location) **1**
(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Frank Stricklin**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

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

7. Birth date of deceased **Aug. 1 1894**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 0 4 hr. min.

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

10. Usual occupation **Laborer**

11. Industry or business **Railroad company**

12. Name **Joe Stricklin**

13. Birthplace **Iron County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Susie Smith**

15. Birthplace **Black Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. McMichael, Record Clerk**

(b) Address **Mo. State San. Mt. Vernon, Mo.**

17. (a) **Removal** (b) Date thereof **Aug 4 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mineral Point**

18. (a) Signature of funeral director **H. D. Fossett**

(b) Address **Mt. Vernon, Mo.**

19. (a) **8-19-47** (b) **Dr. Phillips**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **4th**
year **47** hour **6:32** minute **P** M.

21. I hereby certify that I attended the deceased from **July 23** 19 **46** to **Aug 4** 19 **47**
that I last saw him alive on **Aug 4** 19 **47**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Far Advanced Pulmonary Tuberculosis
Due to _____ **Abt 5 1/2 yrs.**

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

Major findings:
Of operations _____ **1 3 B**
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? _____ (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 _____ **0**

23. Signature **Boyd Wickman** (M. D. or other) _____
Address **Mount Vernon, Mo.** Date signed **Aug 4, 47**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 847-893

Date Filed AUG 27 1947

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 May E. Fossett

Licensed Embalmer No. 4252

P. O. Address Mt. Vernon, Mo.

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.