

FILED FEB 11 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44471

State File No.

Registration District No.

194

Primary Registration District No.

5711

Registrar's No.

1. PLACE OF DEATH:

(a) County McDonald
 (b) City or town Rural Elkhorn
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
None
 (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County McDonald
 (c) City or town Rocky Comfort, Mo.
 (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.....

6030

3. (a) PRINT FULL NAME Freedona Isadora Strickland

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife J. G. Strickland 6. (c) Age of husband or wife if alive Dead years
 7. Birth date of deceased May 9 1871
 (Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name Canen Anderson

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

14. Maiden name Martha Dabbs

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

16. (a) Informant Orville Strickland

(b) Address Stella, Mo. R#2

17. (a) Burial (b) Date thereof 12 28 47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem.

18. (e) Signature of funeral director Wm. Morris By

(b) Address Wheaton, Mo.

19. (a) 2-17-48 (b) O.E. Plummer
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 25
 year 1947 hour 9 minute 15 A.M.

21. I hereby certify that I attended the deceased from Dec-1-47
 to Dec-25-47 1947
 that I last saw her alive on Dec-24-47 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death
Myocarditis
Chronic Nephritis
Influenza
 Due to.....
 Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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?..... (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 or place) (e) Means of injury.....

23. Signature O. E. Plummer (M. D. or other)

Address..... Date signed.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. Newton
District File Number 244-243
Date Filed 2-10-48

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 Wm. Morris Lyle

Licensed Embalmer No. 54439

P. O. Address Wheaton, 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.

Registration District No. 194 Primary Registration District No. 5711 Registrar's No. 2

1. PLACE OF DEATH:
(a) County McDonald
(b) City or town Elkhorn Twp Rural
(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..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Fredora J. Strickland
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married divorced wid
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased May 9 1909
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 1 If less than one day
.....hr.min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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..... (b) Address.....

17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) Feb. 17 1948 (b) O. E. Plumlee
(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 CERTIFICATE
20. DATE OF DEATH: Month Feb Day 17 Year 1948 Hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to.....
that I last saw him/her alive on..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
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?..... (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..... (M. D. or other).....
Date signed.....

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

SUPPLEMENTARY

MOTHER, FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-44471