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K22159

FILED SEP 16 1948

State File No. _____

Registration District No. 2-12

Primary Registration District No. 5779

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Miller

(b) City or town RURAL - FRANKLIN
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Hwy - H-W - Bagnoll Dam 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 16 yrs
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SAMUEL P. STROAD

3. (b) If veteran, name war none

3. (c) Social Security No. _____

4. Sex MALE

5. Color of race White

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LAURA - STROAD

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Feb 3 1890
(Month) (Day) (Year)

8. AGE: Years 58 Months 7 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business FARMING - GEN

12. Name unknown

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

14. Maiden name Ma - May - Wilber

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

16. (a) Informant LAURA STROAD

(b) Address ELDON - MO

17. (a) BURIAL (b) Date thereof 9-10-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dooloy - Cem

18. (a) Signature of funeral director Kirk M. Papp

(b) Address ELDON MO

19. (a) 9-10-48 (b) Cilveretta Waltz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miller

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. Hwy - H-W - Bagnoll Dam
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 9
year 1948 hour 2:15 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Blow by runaway truck striking woman
Blow by Shell fracture

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1950 ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

Of autopsy 1951

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 66

(b) Date of occurrence 9-9-48

(c) Where did injury occur Eldon, Miller, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Garage Home

(e) While at work? at work (Specify type of place)

23. Signature M. E. Thompson (M. D. or other) 3

Address Tuscumbia, Mo. Date signed 9-9-48

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number
SEP 14 1948
Date Filed

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 Keith M Kaye
Licensed Embalmer No. 3998
P. O. Address Edson Ave

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. 212

Primary Registration District No. 5779

1. PLACE OF DEATH:

(a) County Miller
(b) City or town Rural
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Samuel P. Stoad

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

4. Sex m Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 3
(Month) (Day) (Year)

8. AGE: Years 58 Months 7 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____
(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 CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

1947
117

Piece of broken grinding stone struck head

1948

S-30422