

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7882**
Registrar's No. **78**

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008**

I. PLACE OF DEATH
a. COUNTY **Callaway**

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri** b. COUNTY **Callaway**

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Fulton** c. LENGTH OF STAY (in this place) **1 week**

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Mokane**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Callaway Hospital** d. STREET ADDRESS (If rural, give location) **0**

3. NAME OF DECEASED
a. (First) **George** b. (Middle) **Francis** c. (Last) **Strickland**

4. DATE OF DEATH (Month) (Day) (Year) **March 8, 1950**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Feb. 1, 1883** 9. AGE (In years last birthday) **67** IF UNDER 1 YEAR **1** YEAR **7** IF UNDER 1 HR. **0** HR. **0** MIN. **0**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farmer** 10b. KIND OF BUSINESS OR INDUSTRY **Farm** 11. BIRTHPLACE (State or foreign country) **Missouri** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13a. FATHER'S NAME **Joseph Strickland** 13b. MOTHER'S MAIDEN NAME **Carrie Doyle** 14. NAME OF HUSBAND OR WIFE **Gora S. Strickland**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **no** 16. SOCIAL SECURITY NO. **none** 17. INFORMANT'S SIGNATURE OR NAME **Mrs. George Strickland, Mokane, Mo.** ADDRESS _____

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **ac. Cardio-renal failure** INTERVAL BETWEEN ONSET AND DEATH **5 days**

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **cholecystectomy + repair of hernia on 6/3/50**

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **chr. cholecystitis with cholelithiasis and vesical hernia.**

19a. DATE OF OPERATION **3/7/50** 19b. MAJOR FINDINGS OF OPERATION **chr. cholecystitis, cholelithiasis + vesical hernia** 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **3/1**, 19**50**, to **3/8**, 19**50**, that I last saw the deceased alive on **3/8**, 19**50** and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE **Henry Dandy, M.D.** (Degree or title) 23b. ADDRESS **Fulton, Mo.** 23c. DATE SIGNED **3/9/50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **Mar 10, 1950** 24c. NAME OF CEMETERY OR CREMATORY **Mokane** 24d. LOCATION (City, town, or county) (State) **Mokane, Missouri**

DATE REC'D BY LOCAL REG. **Mar 11-1950** REGISTRAR'S SIGNATURE **Martha Lawrence** 426 25. FUNERAL DIRECTOR'S SIGNATURE **Maugin Funeral Home, Fulton, Mo.** ADDRESS _____

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

APR 20 1950

District File Number

District Health Officer No. 9,

MAR 13 1950

RECEIVED

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

working under my personal supervision.

Student Embalmer No.....

Signed

Walter J. Haines, Jr.

Signed.....

Student Embalmer

Licensed Embalmer No. 4557

P. O. Address Fulton, 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.