

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-040226

STATE FILE NUMBER  
5513

FILED DEC 11 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>St Lukes Hosp.</b>		Length of stay in lb <b>30 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>5049 Wornall Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J.</b> Last <b>Strickler</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>20,</b> Year <b>1958</b>		
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5. SEX <b>m.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1883</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice President, Gas Service Company</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Topeka, Kansas</b>	11. BIRTHPLACE (City and state or country) <b>U. S. A.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Jacob Nissley Strickler</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Jonson</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret Strickler</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes W W I</b>	16. SOCIAL SECURITY NO. <b>495-05-4081</b>	17. INFORMANT <b>Mr. Ray Ratliff - 1224 W 61st Street</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 9 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Ruptured Aortic abdominal aneurysm 9 days</b>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4518</b>
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20c. TIME OF INJURY Hour <b>-</b> Month, Day, Year a.m. <b>-</b> p.m. <b>-</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City</b>	COUNTY <b>Mo.</b>	STATE
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21. I attended the deceased from <b>1955</b> , to <b>Nov. 20-58</b> and last saw him alive on <b>Nov 19 1958</b> . Death occurred at <b>1 A.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>A W Robinson MD</b>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>4635 Wyanette</b>	22c. DATE SIGNED <b>11-20-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/21/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) <b>Kansas City</b>	(State) <b>Mo.</b>
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b>	ADDRESS <b>K. C. Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-21-58</b>	26. REGISTRAR'S SIGNATURE <b>New Marshall</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
A. W. Robinson

All diseases in Part I must be causally related.

24

William A. H. 2:00 PM

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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Eugene J. Kummer*

Licensed Embalmer No. *4633*

P. O. Address *R.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.