

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 3 5 1

FILED VS. DEC 3 0 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6015

UNRECORDED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>14 MOS.</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GEN. HOSP. # 1</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3440 WABASH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ERIC</u> Middle <u>STRICKLAND</u> Last <u>STRICKLAND</u>	4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-1958</u>	9. AGE (last birthday) <u>1 YR.</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>CHILD</u>	11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>HUBERT STRICKLAND</u>	13b. MOTHER'S MAIDEN NAME <u>LOIS McCLOUD</u>	14. NAME OF HUSBAND OR WIFE _____
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>HUBERT STRICKLAND, K.C., MO.</u> Address <u>3440 WABASH</u>
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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) <u>diffuse Bilateral Pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH _____
DUE TO (b) _____		
DUE TO (c) <u>From Drinking Furniture Polish containing Cedar Oil.</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Drank furniture polish</u>
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20c. TIME OF INJURY Hour <u>1:AM</u> Month, Day, Year <u>12/11/1959</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20e. CITY, TOWN, OR LOCATION <u>Kansas city</u> COUNTY <u>Jackson, mo.</u> STATE _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. CITY, TOWN, OR LOCATION <u>Kansas city</u> COUNTY <u>Jackson, mo.</u> STATE _____
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21. I attended the deceased from _____ to _____ and last saw him/her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Deputy Coroner [Signature]</u>	22b. ADDRESS <u>1618 India Ave</u>	22c. DATE SIGNED <u>12/14/59</u>
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23a. BURIAL, CREATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN</u>	23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>
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24. FUNERAL DIRECTOR <u>BROWN-HUDSON, K.C., MO.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>12-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Teva Minshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF WILLMAN

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 Millard B. Pasko

Licensed Embalmer No. 5013

P. O. Address K. C. W.

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.