

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-029394

FILED JUL 27 1960

STATE FILE NUMBER

Registration District No. 353 Primary Registration District No. 6194 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Texas County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Dent</u>															
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Licking</u>		Length of stay in lb <u>in transit</u>		c. CITY OR TOWN <u>Salem</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>Highway 32</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Stricklen street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Larry</u> Last <u>Stricklin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1960</u>															
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</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>4-24-43</u>		9. AGE (last birthday) <u>17</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>			11. BIRTHPLACE (City and state or country) <u>Dent Co Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U S A</u>										
13a. FATHER'S NAME <u>Mont Stricklin</u>				13b. MOTHER'S MAIDEN NAME <u>Lillian Lewis</u>				14. NAME OF HUSBAND OR WIFE <u>none</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>X</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mont Stricklin Salem Mo</u>				Address									
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>Cardiac + pulmonary arrest</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Severe head + internal injuries + severe systemic shock.</u> DUE TO (c) <u>Multiple fractures of arms + ribs.</u>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Collision with truck + motorcycle (at driving on motorcycle)</u>								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											
19. WAS AUTOPSY PERFORMED? YES <input 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.)															
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 <u>107</u>		COUNTY		STATE	
21. I attended the deceased from <u>Death on arrival</u> to <u>5:50 p</u> and last saw <u>her</u> <u>him</u> alive on <u>5:50 p</u> Death occurred at <u>5:50 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>B. J. Myers D.O.</u> (Degree or title)						22b. ADDRESS <u>Lechery, Mo.</u>						22c. DATE SIGNED <u>7-20-60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cem</u>				23d. LOCATION (City, town, or county) (State) <u>Salem Mo</u>											
24. FUNERAL DIRECTOR <u>Spencer Funeral Home Inc</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>July 22, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Alnara E. Hesse</u>													

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Salem, Mo. Emballer's Statement on Reverse Side

MAR 7 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Carl H. Pinner

Licensed Embalmer No. 9371

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.