

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

2528
Do not use this space.

1. PLACE OF DEATH
 (a) County Howard 2 FILED FEB 5 1940 378
 Registration District No. 378
 (b) Township _____ Primary Registration District No. 4222
 (c) City Fayette (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lina Strayer 316
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Divorced</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>unknown</u>				
7. AGE	YEARS <u>50</u>	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House keeper</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year) <u>1/16/40</u>			
	11. Total time (years) spent in this occupation <u>Life</u>			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>				
FATHER	13. NAME <u>Clenton Strayer</u> 1			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u> 0			
MOTHER	15. MAIDEN NAME <u>Hulda Chaaten</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>			
17. INFORMANT (ADDRESS) <u>Sara Meyers Rockport Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Landon Mo</u> DATE <u>Jan 19 1939</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Clifton D. Hurd Home Rock Port Mo.</u>				
20. FILED <u>Feb 5 1940</u> <u>V. O. Bonham</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>1/16 1940</u>
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.	
I last saw <u>her</u> alive on _____, 19____. Death is said to have occurred on the date stated above, at <u>11 A.</u> m.	
The principal cause of death and related causes of importance were as follows: <u>coronary occlusion</u> Date of onset <u>9 4 1939</u>	
Other contributory causes of importance: <u>9 4 1939</u>	
Name of operation _____	Date of _____
What test confirmed diagnosis? _____	Was there an autopsy? <u>no</u>
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? <u>no</u> Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury _____	Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? If so, specify _____ (Signed) <u>W. R. Hawley</u> M. D. _____, (Address) <u>Seargard Mo</u> <u>Coroner</u>	

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4/1/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25-28
Do not use this space.

1. PLACE OF DEATH
 (a) County Howard Registration District No. 378
 (b) Township Fayette Primary Registration District No. 4222 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. PRINT FULL NAME Anna Strayer
 (a) Residence, No. Fayette, Mo. Rockport (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Div

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS 20 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER

13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER

15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____, 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Feb 5 1940 V. A. Bouhan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-16, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. R. Hawkins, M. D.
 (Address) Blisswood

Date of onset _____

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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