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.

APR 23 1940

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

11170
Do not use this space.

1. PLACE OF DEATH
(a) County Iron
(b) Township 106 ...
(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 393
Primary Registration District No. 5541
Registered No.

2. PRINT FULL NAME HENRIETTA STRICKLIN.
(a) Residence, No. BIXBY MO. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. ~~SINGLE, MARRIED~~, WIDOWED, OR ~~DIVORCED~~ (write the word): WIDOW.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF G. H. STRICKLIN.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 22, 1875
7. AGE: YEARS 64 | MONTHS 3 | DAYS 10 | 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. HOUSE WIFE
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) BLACK. MO.

FATHER
13. NAME JOHN HENRY TROLINGER
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) BLACK MISSOURI

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

17. INFORMANT (ADDRESS) S. H. HANSELL. BIXBY MISSOURI.
18. BURIAL, CREMATION, OR REMOVAL PLACE HOME CEMETERY. DATE 2/12 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) LEDCKEL FUNERAL SERVICE IRONTON MISSOURI.
20. FILED April 8, 1940 Mrs. Ina Volner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-10, 1940
22. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1940, to Feb. 10, 1940
I last saw her alive on Jan 25, 1940 Death is said to have occurred on the date stated above, at 10:30 P.m.
The principal cause of death and related causes of importance were as follows:
Coronary Thrombosis
Date of onset
94 P.
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? N
If so, specify
(Signed) H. F. Cresswell M. D.
355 (Address) Potosi Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 Geo P Leuckel

Licensed Embalmer No. 3475

P. O. Address Ironton 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, above space should be left blank.

. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11170

Registration District No. 393 Primary Registration District No. 5348 Registrar's No.

1. PLACE OF DEATH:
(a) County Dent
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Henrietta Strickler
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 64 Months 3 Days 10 If less than one day hrs. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) July 18, 1940 (Date received by local registrar) (b) Mrs. Ina Volner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 10 year 1940 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. F. Cresswell (M. D. or other)
Address Potosi Mo. Date signed

SUPPLEMENTARY

1940
S-11170