

17-39
X23

APR 9 1941

Registration District No. 277

Primary Registration District No. 5610

1. PLACE OF DEATH: Paclade
 (a) County _____
 (b) City or town Stoutland
 (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 _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Woodrow Strawther

3. (b) If veteran, name war _____ 3. (c) Social Security No. 486-250729

4. Sex Male 5. Color or race w 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Theda Strawther 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 29 1914
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>26</u>	<u>11</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Caruth Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Fort Leonard Woods

12. Name M. A. Strawther Government

13. Birthplace Caruth Mo
(City, town, or county) (State or foreign country)

14. Maiden name Theda Roach

15. Birthplace Caruth Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Joe Strawther

(b) Address Meritt Mo

17. (a) Burial & Removal (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Care

18. (a) Signature of funeral director Charles Funeral Home

(b) Address Camplight Mo

19. (a) 3-9-41 (b) Lo E. Costen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Paclade 53
 (c) City or town Stoutland
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1941 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from March
7, 1941, to March 8, 1941;
that I last saw him alive on March 8, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death probable internal hemorrhage

Due to Gastric ulcer

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1170

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Lo E. Costen (M. D. or other) 1

Address Stoutland Mo Date signed 3-9-41

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

000

RECEIVED

District Health Officer No. 7,

District File Number 4-41-597

Date Filed 4-7-41

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, fact should be so stated above.

No. 2
-1-4-41
-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11142

Registration District No. 2077

Primary Registration District No. 5610

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Mayfield
(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 _____)
In this community _____
years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Woodrow Strawther
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex m
5. Color or race w
6. (a) Single, widowed, married, divorced married
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 26 Months 11 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 3-9-1941 (b) C. E. Castore
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar day 8
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____
that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature C. E. Carlson (M. D. or other) _____
Address Stoutland Date signed _____

SUPPLEMENTARY

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

1941
S-11142

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, fact should be so stated above.