

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 24 1943

Registration District No. 1067

Primary Registration District No. 4261

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Iron

(b) City or town Hurdland

(c) Name of hospital or institution: none

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 65 years (Specify whether years, months or days)

In this community 65 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 52

(c) City or town Hurdland 0

(If outside city or town limits, write "RURAL")

(d) Street No. .... (If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME HOMER CLARK STRICKLER

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MARGARET

6. (c) Age of husband or wife if alive 17 years (Year) 1876

7. Birth date of deceased (Month) Nov (Day) 17 (Year) 1876

8. AGE: Years 66 Months 4 Days 9 If less than one day hr. min.

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

10. Usual occupation merchant

11. Industry or business

12. Name Geo. W. Strickler

13. Birthplace Pa. 1 (City, town, or county) (State or foreign country)

14. Maiden name Josephine Prange

15. Birthplace Ohio 1 (City, town, or county) (State or foreign country)

16. (a) Informant Margaret Strickler

(b) Address Hurdland Mo.

17. (a) burial (b) Date thereof 3/28/43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 200 E. Hurdland

18. (a) Signature of funeral director Geo B Casley Jr.

(b) Address Hurdland Mo.

19. (a) April 6 1943 (b) Will Northcutt (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1943 hour 4 minute 0 P.M.

21. I hereby certify that I attended the deceased from April 1943 to March 15 1943 and that death occurred on the date and hour stated above.

that I last saw h. in alive on March 15 1943

Immediate cause of death Cerebrovascular Duration

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 12481

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

Signature H. G. Schuch (M. D. or other) D.O.

Address Waring Mo. Date signed 3/27/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKES A CERTAINLY

201  
101  
RECEIVED

District Health Officer No. 10

District File Number 5-43-906

Date Filed MAY 21 1943

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 George Beasley Jr.

Licensed Embalmer No. 3758

P. O. Address Huddland

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 18214Registration District No. 169Primary Registration District No. 4261Registrar's No. 105

## 1. PLACE OF DEATH:

- (a) County Knox  
 (b) City or town Hurdland  
 (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 Homer Clark Strickler

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
- m

6. (b) Name of husband or wife 6. (c) Age of husband or wife if
- 
- alive \_\_\_\_\_ years

7. Birth date of deceased
- Nov. 17 1866
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
- 
- 66
- 4
- 18
- min.

9. Birthplace
- Doniphan
- 
- (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)  
 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) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

## 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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month
- Mar
- Day
- 12
- Year
- 1943
- Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_, 19\_\_\_\_

Due to \_\_\_\_\_, 19\_\_\_\_

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 sta-  
tistically.

## 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-18214