S. No. 2
0M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 24 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20639

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2490

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2700 Tracy 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. Recordo Hotel 811 E. Armour
(If rural, give location)

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

3. (a) PRINT FULL NAME David Thomas Sydenstricker

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 2 Widower

6. (b) Name of husband or wife Minnie Sydenstricker

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

7. Birth date of deceased Mar 29 (Month) 1862 (Day) (Year)

8. AGE: Years 81 Months 2 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired Merchant

11. Industry or business Self

FATHER
12. Name Thos. B. Sydenstricker
13. Birthplace W Va 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace no Record 4 (City, town, or county) (State or foreign country)

16. (a) Informant Thomas B Sydenstricker
(b) Address 560 7 Tracy

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 1 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Slater Mo

18. (a) Signature of funeral director Mrs C L Fonter
(b) Address 918 Brooklyn

19. (a) 6-1-43 (Date received local registrar) (b) N. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1943 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 15 43, 19.., to June 1, 1943
that I last saw him alive on May 31, 1943;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	2 day
Due to Myocardial Failure	3 day
Due to Rep Hip Nailed six weeks	
Other conditions ago (Include pregnancy within 3 months of death)	1

Major findings:
Of operations 18 6a 10
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) Acc 123
(b) Date of occurrence May 15 1943
(c) Where did injury occur? K. C. Jack Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury Fall

23. Signature Dr John O Kremer (M. D. or other)
Address 140 2 Bigelow Date signed 6/1/43

(Licensed Embalmer's Statement on Reverse Side)

3118

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. Jas E. Newton

Licensed Embalmer No. 1621

P. O. Address. 918 Broadway

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.