

FILED FEB 8 1944

Registration District No. **358**

Primary Registration District No. **4523**

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

1. PLACE OF DEATH:

(a) County Vernon

(b) City or town Schell city  
(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 1  
In this community About 4 1/2 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon **108**

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

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

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. 0

3. (a) PRINT FULL NAME CARIE ANN STROSNIDER

MEDICAL CERTIFICATION

3. (b) If veteran, name war No 3. (c) Social Security No. No

20. DATE OF DEATH: Month Jan. day 19, year 1944 hour 7: minute 30 A.M.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

21. I hereby certify that I attended the deceased from Jan. 5, 1944 to Jan. 19, 1944; that I last saw him alive on, 1944; and that death occurred on the date and hour stated above.

7. Birth date of deceased. April 21, 1863  
(Month) (Day) (Year)

Immediate cause of death. Lobar Pneumonia **3 days.**

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>8</u>	<u>28</u>	hr. _____ min. _____

Due to Influenza **10 days.**

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

Due to 2 ga

10. Usual occupation House Keeper

Other conditions myocarditis **5 yrs.**  
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name John Jackson Strosnider

13. Birthplace West Va  
(City, town, or county) (State or foreign country)

14. Maiden name Hances Jane Wilson

15. Birthplace W. Va  
(City, town, or county) (State or foreign country)

Major findings: none Performed

Of operations \_\_\_\_\_

Of autopsy none Performed

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Schell City, Mo

22. If death was due to external causes, fill in the following:

(b) Address \_\_\_\_\_

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

17. (a) Burial (b) Date thereof Jan. 20 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation Green Lawn Cemetery

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

18. (a) Signature of funeral director Ante Lewis  
(b) Address Schell City, Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

19. (a) 1-20-44 (b) Ante Lewis  
(Date received local registrar) (Registrar's signature)

23. Signature M. D. Bjerk (M. D. or other) D.O.  
Address Rockville Date signed 1/20/44

APR 8 1967  
RECEIVED

District Health Officer No. 71  
District File Number 1-44-91  
Date Filed 2-7-44

**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 Marion M. Lewis  
Licensed Embalmer No. 3084  
P. O. Address Schell City, 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, fact should be so stated above.**