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35897

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

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15367

BUREAU OF THE GENERAL REGISTER  
FILED MAY 8 1944

State File No. \_\_\_\_\_

Registration District No. 25-5

Primary Registration District No. 5877

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Alton Finney Twsp. Rural  
(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 \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

(c) City or town Alton (Rural) 0  
(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 \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Thomas Jefferson Strain

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

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

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

7. Birth date of deceased March 22 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>9</u>	<u>13</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

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

12. Name Thomas Strain

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

14. Maiden name Unknown

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

16. (a) Informant Walter Strain

(b) Address Alton, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/44  
(Month) (Day) (Year)

(c) Place: burial or cremation New Salem Cem.

18. (a) Signature of funeral director Geo. Parr  
(b) Address Thayer, Mo.

19. (a) 4/20 1944 (b) Henry M. Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5  
year 1944 hour 8 minute 00 A.M.

21. I hereby certify that I attended the deceased from on March the 1<sup>st</sup> 1944, to \_\_\_\_\_ 19\_\_\_\_; that I last saw him alive on March the 1<sup>st</sup> 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure Duration \_\_\_\_\_

Due to Stomach trouble and old age

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations _____	ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED	PHYSICIAN _____ Underline the cause to which death should be charged statistically.
Of autopsy _____		

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? None on Farm Bachelor  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature L. B. Forest (M. D. or other) \_\_\_\_\_  
Address Alton Mo Date signed 3/6/44

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**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.**

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X36930

State File No. May  
Registrar's No. 10

Registration District No. 255 Primary Registration District No. 5877

1. PLACE OF DEATH:

(a) County Oregon  
(b) City or town Astoria Rural Pineside  
(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 60 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas J. Strain

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 W

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

7. Birth date of deceased: March 2 1892  
(Month) (Day) (Year)

8. AGE: Years 11 Months 9 Days 3 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Hugh W. Edwards (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Oregon  
(c) City or town Rural Pineside  
(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 March 1944 year 15 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Failure  
some myocarditis  
Due to 93d  
stomach trouble and  
old age

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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

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SUPPLEMENTAL

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