

FILED SEP 13 1945

Registration District No. 187

Primary Registration District No. 5694

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town R.R. #3 Chillicothe, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Chillicothe  
10 Miles Northwest-Chillicothe, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 89 years (Specify whether  
In this community 89 years  
years, months or days)

3. (a) PRINT FULL NAME AMANDA JANE STRAIT

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife William Strait 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 10th. 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 5 28 hr. min.

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

10. Usual occupation Housewife

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

MOTHER FATHER { 12. Name John C. Weaver

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

14. Maiden name Dellia Flecher

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

16. (a) Informant Ira Strait

(b) Address R.R. #3 Chillicothe, Missouri

17. (a) Burial (b) Date thereof 8-11-'45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brassfield Cemetery

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

(b) Address Chillicothe, Missouri.

19. (a) Aug 10 (b) Lonella Curry  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Livingston  
(c) City or town Rural-Chillicothe, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.R. #3 Chillicothe, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 8th. year 1945 hour 12:20 minute P. M.

21. I hereby certify that I attended the deceased from July 28th 1945 to August 6 1945.

that I last saw her alive on August 6th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia 3 days

Due to Cerebral hemorrhage 1 day

Due to Hypertension 1 year

Other conditions Cardio-renal syndrome 1 year  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: none  
Of operations none  
Of autopsy none  
Underline the cause to which death should be charged statistically.

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

(c) 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) (d) Means of injury 2

23. Signature Joseph H. Proctor (M. D. or other) DB  
Address 702 Jackson, Chillicothe, Mo. Date signed 8-9-45

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

**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.....  
Frank L. Smiley....., Registered Apprentice No.....  
working under my personal supervision.

Signed Frank L. Smiley  
Licensed Embalmer No. 470

P. O. Address Wheeling, Missouri.

**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.**