

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23319**
Registrar's No. **6**

FILED JUL 21 1947

Registration District No. **14** Primary Registration District No. **4028**

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

1. PLACE OF DEATH:
 (a) County **Barton**
 (b) City or town **Liberal Mo**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
no
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **55 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Barton**
 (c) City or town **Liberal Mo**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Walton Ave**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Charles Strickland**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **4** day **6**
 year **47** hour **11** minute **-** M.
21. I hereby certify that I attended the deceased from
4/6 19**47** to **4/6** 19**47**
 that I last saw him alive on **4/6** 19**47**
 and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Alice Strickland**
 6. (c) Age of husband or wife if alive **67** years
 7. Birth date of deceased: **12** **11** **71**
(Month) (Day) (Year)

Immediate cause of death **apoplexy**
 Duration **7 yrs**
 Due to **hypertension**
 Due to **43A**

8. AGE: Years **75** Months **3** Days **25**
 If less than one day **-** hr. **-** min.

Other conditions (Include pregnancy within 3 months of death) **43A**
PHYSICIAN
 Major findings: **Paralysis of left side**
 Of operations _____
 Of autopsy **no**
 Underline the cause to which death should be charged statistically.

9. Birthplace **Lima** **Ill**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Farmer**

MOTHER FATHER
 11. Industry or business _____
 12. Name **Jason Strickland**
 13. Birthplace **Ill**
(City, town, or county) (State or foreign country)
 14. Maiden name **Julia Ann Harness**
 15. Birthplace **Ill**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Alice Strickland**
 (b) Address **Liberal Mo**
 17. (a) **Burial** (b) Date thereof **4-8-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **ROSE BANK CEMETERY - Mulberry Road**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **no**
 (b) Date of occurrence **0**
 (c) Where did injury occur? **0**
(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? **0** (e) Means of injury **0-2**

18. (a) Signature of funeral director **Arthur Funeral Home**
 (b) Address **Lamar Mo**
 19. (a) **April 7 47** (b) **Antonie White**
(Date received local registrar) (Registrar's signature)

23. Signature **A. J. Edalmen** (M. D. or other)
 Address **Liberal Mo** Date signed **4/7/47**

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.....

Chas. Gibson

Licensed Embalmer No.....

2299

P. O. Address.....

Samoa 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.