

Registration District No. _____ Primary Registration District No. 1002

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: Menorah Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days)

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2813 Cherry St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Robert Lee Strickland

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single widowed, married, divorced Child

6. (b) Name of husband or wife Child

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

7. Birth date of deceased: Aug. 26th, 1947
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26th, year 1947 hour 5 minute P.

21. I hereby certify that I attended the deceased from Aug 26 - 7:10 PM Aug 26 - 1947 to 5:30 PM Aug 26 1947

that I last saw him alive on Aug 26 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity

Duration 7 mos.

8. AGE:

Years	Months	Days	If less than one day
			<u>7</u> hr. _____ min.

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

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

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name Lawrence Strickland

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

14. Maiden name Virginia Lea Smith

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

Major findings: 151

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Lawrence Strickland

(b) Address 2813 Cherry St.

17. (a) Burial (b) Date thereof 8/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Earp & Sons

(b) Address 4139 East 15th, St

19. (a) 8-27-47 (b) Steraldine Holmset
(Date received local registrar) (Registrar's signature)

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 _____

Signature Ray Goodson (M. D. or other) _____

Address 1107 Grand Ave Date signed _____

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

*Dr. Johnson
Resident Body
11-1-1950*

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..... *John B. [Signature]*
Licensed Embalmer No. *2953*
P. O. Address *11. C. [Signature]*

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.