

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27141
3325

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (In this place) <u>61 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>216 Clinton Place</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ira</u>	b. (Middle) <u>S</u>	c. (Last) <u>Strother</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>August 1, 1950</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify). <u>widowed</u>	8. DATE OF BIRTH <u>Sept. 26, 1863</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>B. A. Spencer</u>	13b. MOTHER'S MAIDEN NAME <u>Caroline Austin</u>	14. NAME OF HUSBAND OR WIFE <u>Albert R. Strother, dec.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT'S SIGNATURE OR NAME KC Mo. ADDRESS <u>Mrs. Mildred F. Strother, 216 Clinton Pl.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma rectum</u>		<u>4 years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>metastatic ca lungs</u>		<u>2 months</u>
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>154h</u>

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 1946, 19 , to Aug 1, 1950, that I last saw the deceased alive on July 31, 1950, and that death occurred at 4⁰⁰a m., from the causes and on the date stated above.

23a. SIGNATURE <u>Donald McFarland MD</u> (Degree or title)	23b. ADDRESS <u>315 Alameda Rd</u>	23c. DATE SIGNED <u>Aug 1, 1950</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/3/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-3-50</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCLURE</u>	ADDRESS <u>Kansas City, Mo.</u>
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

S. J. Allen

Signed _____

Student Embalmer

Licensed Embalmer No. _____

P. O. Address _____

*1415
H. E. M.*

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.