

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32201

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3978300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> <input checked="" type="checkbox"/>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hosp.</b>			Length of stay in 1b <b>31 yrs.</b>		STREET ADDRESS (If outside, give location) <b>4107 McGee Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE FRANKLIN STRICKLAND, Sr.</b>				4. DATE OF DEATH Month Day Year <b>August 23, 1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 16, 1885</b>		9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Patrolman-K.C.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Police Dept.</b>		11. BIRTHPLACE (City and state or country) <b>Gridley, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Charles W. Strickland</b>			13b. MOTHER'S MAIDEN NAME <b>Lucy Wise</b>			14. NAME OF <del>DECEASED'S</del> WIFE <b>Edna A. Strickland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>496-24-8685</b>		17. INFORMANT Address <b>Mrs. Edna A. Strickland, K.C., Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>metastatic &amp; general</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>cachexia.</b> DUE TO (c) <b>16 month</b> <b>157+</b>							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>1955</b> to <b>Aug. 57</b> and last saw her alive on <b>8-23-57</b> Death occurred at <b>4:30 p.m. Aug 23</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>F. H. Hodgson M.D.</b>				22b. ADDRESS <b>4301 Main</b>		22c. DATE SIGNED <b>8/24/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 26, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>		23d. LOCATION (City, town, or county) (State) <b>Jackson County, Missouri</b>				
24. FUNERAL DIRECTOR ADDRESS <b>FREEMAN MORTUARY, Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>8-24-57</b>		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
F. H. HODGSON

All diseases in Part I must be causally related.



4301 MAIN  
VA. 1-3323

11:15 A.M.

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.

Student .....  
Signature of Student Embalmer

Signed *Clayton Barnes*

Licensed Embalmer No. 4793  
P. O. Address K. E. Ma

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.