

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. J. Haugh

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32202

STATE FILE NUMBER

3852

FILED SEP 19 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3852

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wheatley Hosp.</u>			Length of stay in lb <u>40 Yrs.</u>		d. STREET ADDRESS <u>2407 Campbell St.</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Strickland</u> Last <u></u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>57</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 5, 1900</u>		9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Products</u>		11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Brazzie Strickland</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
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>487-05-7156</u>		17. INFORMANT <u>Irene Strickland 2407 Campbell</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>331X</u>		
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 <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>									
20d. INJURY OCCURRED WHILE AT WORK <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 <u>7-25-57</u> and last saw <u>her</u> alive on <u>8-12-57</u> Death occurred at <u>545 1/2</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (License or title) <u>B. J. Haugh Sr. M.D.</u>				22b. ADDRESS <u>2200 East 18th St.</u>		22c. DATE SIGNED <u>8/13/57</u>			
23a. BURIAL CREMATION (Removal to cemetery) <u>Burial</u>		23b. DATE <u>8-17-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo. Kans.</u>				
24. FUNERAL DIRECTOR <u>Manlove & Williams 1729 Lydia</u>			25. DATE RECD. BY LOCAL REG. <u>8-16-57</u>		25. REGISTRAR'S SIGNATURE <u>neva minshall</u>				

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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 *D. J. Mantone Jr.*
Licensed Embalmer No. *39*

P. O. Address *3712 E.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.