S. No. 2
M—5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 3 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Hyde

State File No. 44618

Registration District No. 336 Primary Registration District No. 6119 Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Alley
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Shannon 101
(c) City or town Alley 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Thomas J. Strain
3. (b) If veteran, name war None
3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Ellen Strain
6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Nov (Month) 16 (Day) 1852 (Year)

8. AGE: Years 95 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Crawford Co. (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Daniel Strain 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Malinda Miller
15. Birthplace Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant J. R. Strain
(b) Address Alley, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation Culpepper Cemetery

18. (a) Signature of funeral director Duncan Funeral Home
(b) Address Mountain View, Mo.

19. (a) 1-13-48 (Date received local registrar) (b) Mabel Keen (Registrar's signature) 10

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23
year 1947 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 18 - 1947, to Dec 23 - 1947; that I last saw h alive on Dec 18 - 47 19; and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death Uremic Poison	
Due to Stricture of Urethra	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 101
(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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Frank Hyde (M. D. or other)
Address Eminence Mo Date signed 1-27-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 5,
District File No. 1487
Date Filed 1-29-46

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 Joe R. Duncan

Licensed Embalmer No. 4325

P. O. Address Mtn. View, 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.

S. No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

44618

State File No. [illegible]

Registration District No. 236 Primary Registration District No. 6114 Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Alley

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town

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

(d) Street No.

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Thomas J. Strain

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. (Month) 16 (Day) [illegible] (Year)

8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month [illegible] Day 23

year 1947 hour [illegible] minute M.

21. I hereby certify that I attended the deceased from [illegible], 19..., to [illegible], 19...; that I last saw h[illegible] alive on [illegible], 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Dec 12-47

(c) Where did injury occur? In home (City or town) Alley (County) Shannon (State) Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fell in home: Fracturing hip

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

S-44618