

Registration District No. 774

Primary Registration District No. 4465

Registrar's No. 919

1. PLACE OF DEATH:

(a) County. St. Francois  
(b) City or town. Flat River, Mo  
(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 21

FILED FEB 7 1940  
2

3. (a) PRINT FULL NAME Mrs. Julia Etta Straughn  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Mr. Wm J. Straughn  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 3 1856  
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 18  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Genevieve County, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

MOTHER FATHER  
12. Name Mr. William Tinkerton  
13. Birthplace Missouri  
14. Maiden name Elizabeth Richard Tinkerton  
15. Birthplace Madison, Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Madeline Welland (daughter)  
(b) Address Flat River, Mo

17. (a) Burial (b) Date thereof Jan 23-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park View, Farmington

18. (a) Signature of funeral director Alvin W. Hall  
(b) Address Flat River, Mo

19. (a) 1-23-40 (b) O. B. Turner  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois  
(c) City or town Flat River  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 21  
year 40 hour 1 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 1-10-40  
\_\_\_\_\_ 19\_\_\_\_ to 1-21 1940  
that I last saw her alive on 1-20 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 10 days

Due to arteriosclerosis general  
chr interstit. nephritis

Due to \_\_\_\_\_  
Other conditions burn 20 degrees on back  
(Include pregnancy within 3 months of death) from 11/19/39

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) \_\_\_\_\_  
(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 \_\_\_\_\_

23. Signature M. G. Gabe (M. D. or other) \_\_\_\_\_  
Address Lexington Mo Date signed 1-22-40

N. B.—Every item of information should be carefully supplied: AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

181  
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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Alvin W. Hood:

Licensed Embalmer No. 2780.

P. O. Address Flat River, 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **3611**  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **274**

Primary Registration District No. **4465**

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

1. PLACE OF DEATH:

(a) County **St. Francois**  
(b) City or town **Flour River**  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME **Mrs. Julia Etha Strangher**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years **83** Months **9** Days **8** If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

20. DATE OF DEATH. Month **Jan** day **21**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**  
**Arteriosclerosis**

Due to **Chr. Interstitial Nephritis**

Due to **Burns**

Other conditions **Burns 2d degree**  
(Include pregnancy within 3 months of death)  
**on back from N.W.**

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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, homicide, or other \_\_\_\_\_ **slight burn on**

(b) Date of occurrence. **1-10-40**

(c) Where did injury occur? **Flour River, Missouri**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **in home - slight burn**  
(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury **hot water bottle**

23. Signature **H. P. Gabe** (M. D. or other) \_\_\_\_\_  
Address **DeLoe** \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

