SEP 17 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30134

1. PLACE OF DEATH
County Moniteau
Township Walker
City California (No. St. Ward)

Registration District No. 571
Primary Registration District No. 4335
File No.
Registered No. 41

2. FULL NAME Katheryn Strickfaden

(a) Residence, No. St., Ward. (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
81	8	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co. Mo.

FATHER

13. NAME Frank Stretz

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER

15. MAIDEN NAME Magdaline Rider

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

17. INFORMANT Mrs John Baker
(ADDRESS) California, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Catholic Cem DATE 8/11 1934

19. UNDERTAKER Hefleman & Friedmeyer
(ADDRESS) California Mo

20. FILED 8-11-1934 H R Bopepy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 10 1934

22. I HEREBY CERTIFY, That I attended deceased from August 9, 1934, to , 19 .

I last saw her alive on August 10 1934 Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Paralysis
Chronic Nephritis
131
82D

Date of onset

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

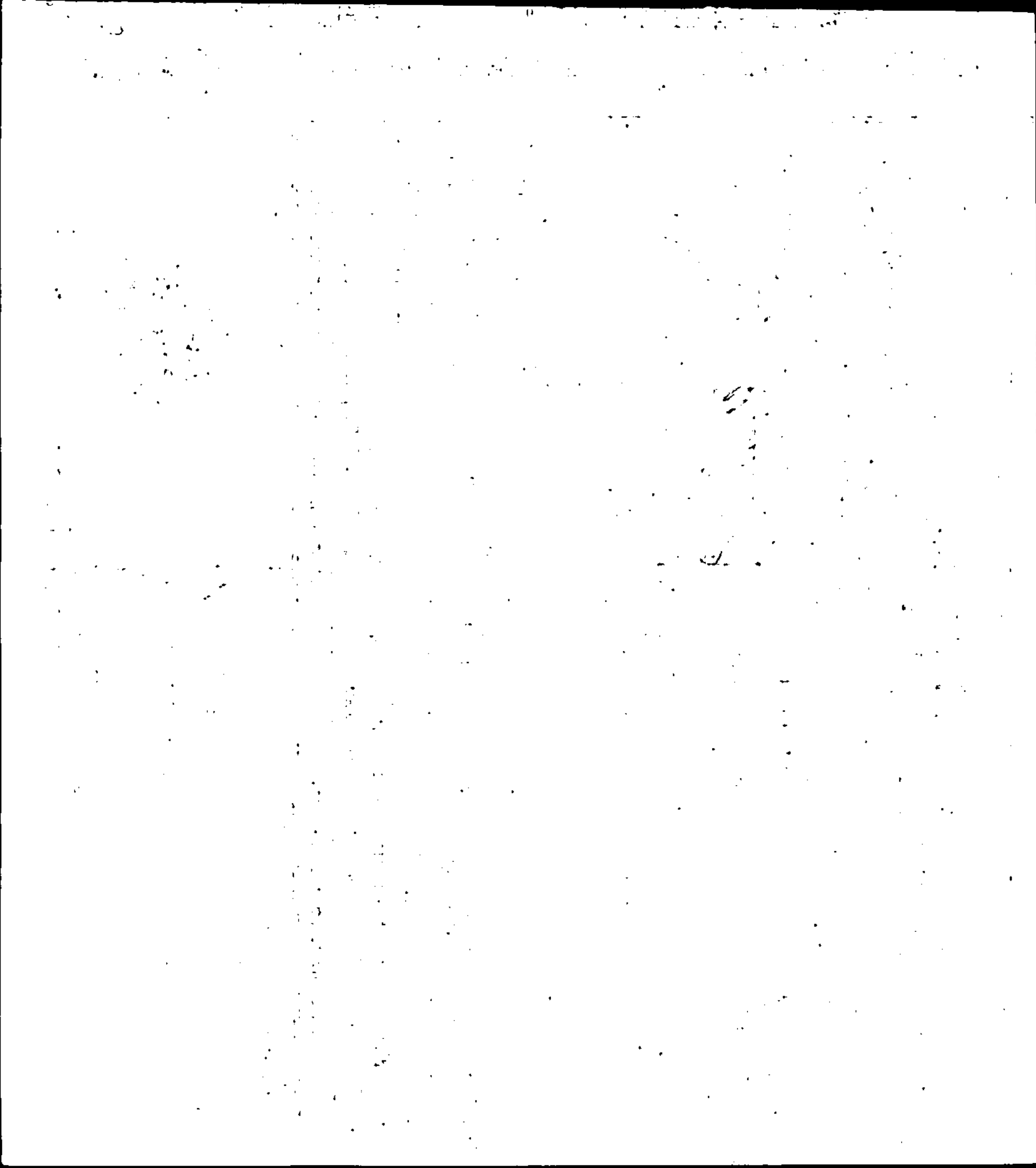
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) L McGray, M. D.
(Address)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.



#2 Moniteau

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Kathryn Strickfaden
Who died at ______ on Aug - 10 - 1934
Residence: No. ______ St. ______
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years ______ Months ______ Days ______
Sex F Color or race W ~~Single, married,~~ widowed ~~or divorced~~; ______

Date of birth 12 - 9 - 1852 Age: Years 81 Months 8 Days 1

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ______

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. ______

Date deceased last worked at this occupation: Month ______ Year ______
Birthplace (State or country) ______
Birthplace of father (State or country) ______
Birthplace of mother (State or country) ______
Principal cause of death: Paralysis, Chronic Nephritis: Senile Paralysis

Other contributory causes of importance ______
Name of operation ______ Date of ______
What test confirmed diagnosis? ______ Was there an autopsy? ______
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ______ Date of injury ______, 19____
Where did injury occur? ______
(Specify city or town, county and State)

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Specify whether injury occurred in industry, in home, or in public place.

______

Manner of injury ______
Nature of injury ______
Was disease or injury in any way related to occupation of deceased? ______
If so, specify ______
Name of physician ______
Address of physician ______
Signature of Registrar X H R Popejoy M.D. Date filed 8-11-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 571

Primary Reg. Dist. No. 4335 —

Very truly yours,

E. T. McGaugh

Registrar

Special Agent.

S-30134

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