

FILLED NOV 12 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36274

Registration District No. 821

Primary Registration District No. 4553

Registrar's No.

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston  
(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 Missouri (b) County Scott  
(c) City or town Sikeston  
(If outside city or town limits, write "RURAL")  
(d) Street No. 109 N. Stoddard  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Addie Marie Streiff

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Pete Streiff 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased Sept. 23 1897  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
44 0 16 hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name George Bunyard

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

14. Maiden name Unknown

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

16. (a) Informant Pete Streiff

(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof 10-11-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H.J. Welsh

(b) Address Sikeston, Mo.

19. (a) 10-6-41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9  
year 1941 hour 7 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from July 14 1941 to Oct 9 1941  
that I last saw her alive on Oct 9 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death, Coronary thrombosis of blood vessel with myocardial infarction with asphyxia  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations no

Of autopsy no

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

(a) Accident, suicide, or homicide (specify) no

(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 [Signature] (M. D. or other) \_\_\_\_\_

Address Sikeston Mo Date signed 10-29-41

Duration

6 mo

6 mo

4 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

50

vertical mark

✓

RECEIVED

District Health Office No 2.

District File Number 1141-1505

Date Filed 11/10/41

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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.....

*Raymond Crews*

Licensed Embalmer No. 3467

P. O. Address. Sikeston 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.**