S. No. 2
M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41138

FILED JAN 11 1946

Registration District No. 113 Primary Registration District No. 4185 Registrar's No.

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

1. PLACE OF DEATH:
(a) County FRANKLIN
(b) City or town ST. CLAIR
(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 83 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County FRANKLIN
(c) City or town ST. CLAIR
(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)
If yes, name country

3. (a) PRINT FULL NAME HULDA JANE STRICKER
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 GUSTAV STRICKER
6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEPT (Month) 24 (Day) 1862 (Year)

8. AGE: Years 83 Months 3 Days 5 If less than one day hr. min.

9. Birthplace FRANKLIN COUNTY (City, town, or county) MO (State or foreign country)
10. Usual occupation HOUSE WIFE
11. Industry or business

MOTHER
12. Name PERRY CALVIN
13. Birthplace (City, town, or county) MO (State or foreign country)

FATHER
14. Maiden name MARY ANN REED
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant ELASCO STRICKER
(b) Address ST. LOUIS, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 1 1946 (Month) (Day) (Year)
(c) Place: burial or cremation PROSPECT CEMETERY
18. (a) Signature of funeral director Coley & Lepot
(b) Address ST. CLAIR, MO
19. (a) 12-30-45 (Date received local registrar) (b) E. N. Worthington (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 8 day 29 year 1945 hour 8 minute P M.
21. I hereby certify that I attended the deceased from Nov. 1, 1945, to Dec 8, 1945; that I last saw her alive on Dec 29, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	
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)
(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

23. Signature (M. D. or other)
Address Date signed 1/3/46

1496 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-10-46

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 H. M. Lenot

Licensed Embalmer No. 3601

P. O. Address St. Clair, 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.