

No. 2
1-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25794

FILED JUL 21 1946

Registration District No. 318 Primary Registration District No. 1003 State File No. _____ Registrar's No. 6391

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DE PAUL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 DAY (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 6648 OAKLAND (If rural, give location) 49
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME INFANT-THURMAN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 19
year 1946 hour 12 minute 50 P. M.
21. I hereby certify that I attended the deceased from July 19
1946 to July 19 1946
that I last saw him alive on July 19 1946
and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JULY 19 - 46
(Month) (Day) (Year)

Immediate cause of death: Robert Johnson Strickland
Injury Birth Injury
Due to Labor Duration _____
Due to _____

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

Other conditions: _____
(Include pregnancy within 3 months of death) None

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

10. Usual occupation _____
11. Industry or business _____
12. Name RUFUS-STHURMAN
13. Birthplace DESDEMONA TEXAS
(City, town, or county) (State or foreign country)
14. Maiden name CATHERINE J. OLIVER
15. Birthplace ST JOHNS-NEWFOUNDLAND
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
16. (a) Informant RUFUS-STHURMAN 2
(b) Address 6648 OAKLAND AVE
17. (a) PURIAL (Burial, cremation, or removal) (b) Date thereof JULY 20 1946
(Month) (Day) (Year)
(c) Place: burial or cremation Morningside PARK
18. (a) Signature of funeral director G. J. Bredbeck
(b) Address 4386 Lindbergh
19. (a) JUL 20 1946 (Date received local registrar) G. J. Bredbeck (Registrar's signature)

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)
(c) Means of injury _____
23. Signature S. M. Riordan (M. D. or other) 0 MA
Address 4500 Olive St Date signed 7/19/46

(Licensed Embalmer's Statement on Reverse Side)

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

25794

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.....

Licensed Embalmer No.....

P. O. Address.....

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.