

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 1003

State File No. 25329
Registrar's No. 6526

FILED AUG 13 1949

318

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
c. LENGTH OF STAY (in this place) 9 days		d. STREET ADDRESS (If rural, give location) 23-1440 N 15th St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips			

3. NAME OF DECEASED a. (First) Mary			b. (Middle) Strickland			c. (Last) Strickland			4. DATE OF DEATH (Month) (Day) (Year) July 25, 1949		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH 8-20-1881			9. AGE (In years last birthday) 67		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Batesville, Mississippi				12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME James Dukes		13b. MOTHER'S MAIDEN NAME Kizzie Dukes		14. NAME OF HUSBAND OR WIFE Sherman, Stricklin.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Class Jones	
				ADDRESS I440, A. No. 15th Street	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis				INTERVAL BETWEEN ONSET AND DEATH Unk	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW INJURY OCCURRED _____			

22. I hereby certify that I attended the deceased from July 16, 1949, to July 25, 1949, that I last saw the deceased alive on July 25, 1949, and that death occurred at 6:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE A. J. Thompson (Degree or title) M D		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 7-25-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-29-49		24c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery	
				24d. LOCATION (City, town, or county) (State) Tunica, Miss.	

DATE RECD BY LOCAL HEALTH DEPT. JUL 28 1949		REGISTRAR'S SIGNATURE J. B. Carter		25. FUNERAL DIRECTOR'S SIGNATURE John H. Houston		ADDRESS 2829 Washington.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

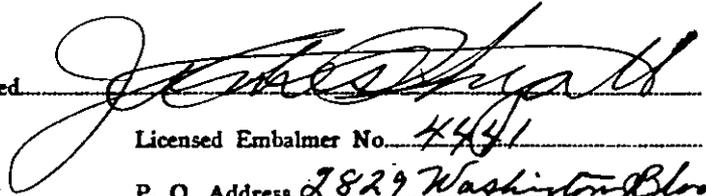
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____


Licensed Embalmer No. 4431
P. O. Address 2829 Washington Blvd

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.