

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32226  
State File No. \_\_\_\_\_  
Registrar's No. 8558

FILED OCT 13 1949

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>8558</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b>				b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis</b>		c. LENGTH OF STAY (in this place) <b>16 Days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Bel-Nor</b>		96 2 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Deaconess Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>W 2856 Clearview Drive</b>				1	
3. NAME OF DECEASED (Type or Print) <b>Beatrice</b>			a. (First) _____		b. (Middle) <b>E.</b>		c. (Last) <b>Strickland</b>		
4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 4th, 1949</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>April 30th, 1906</b>	
9. AGE (In years last birthday) <b>43</b>		IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 1 YEAR Days <b>4</b>		IF UNDER 1 YEAR Hours _____		IF UNDER 1 YEAR Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Venice, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Fred Schlef</b>			13b. MOTHER'S MAIDEN NAME <b>Caroline Wiegmann</b>			14. NAME OF HUSBAND OR WIFE <b>Towne S. Strickland</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>T. S. Strickland, 2856 Clearview Dr.</b>				ADDRESS <b>Bel-Nor</b>	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Metastatic Malignancy of Breast</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Adeno Sarcoma of breast</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>metastatic nodes of lymph. several &amp; auxiliary nodes.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 weeks</b> <b>2 years</b> <b>6 months</b>	
19a. DATE OF OPERATION <b>1947</b>		19b. MAJOR FINDINGS OF OPERATION <b>Adeno Sarcoma of breast (left)</b>						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) <b>50</b>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>170X</b>		22. I hereby certify that I attended the deceased from <b>7/22</b> , 19 <b>49</b> , to <b>10/4</b> , 19 <b>49</b> , that I last saw the deceased alive on <b>10/4</b> , 19 <b>49</b> , and that death occurred at <b>2:02</b> p.m., from the causes and on the date stated above.					
23a. SIGNATURE <b>George A. Morant</b>			(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>4032 W. Flourens Ave</b>		23c. DATE SIGNED <b>10/4/49</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10/6/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>			
DATE REC'D BY LOCAL REG. <b>OCT 5 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sasser</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F. Feutz</b>		ADDRESS <b>4828 Natural Bridge Blvd.</b>			

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

4051  
No. 2820  
107012 + 4706

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed *John A. Merian*  
Licensed Embalmer No. *1786*

P. O. Address *St Louis 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.