

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16677

State File No.

No. 300
10-48

FILED MAY 9 1953

BIRTH NO.		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1178</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>[REDACTED]</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Vinita Park</u>		c. LENGTH OF STAY (in this place) <u>6 Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		<u>2059</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>8208 Page</u>				d. STREET ADDRESS (If rural, give location) <u>6130 Plymouth</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Margaret</u> b. (Middle) <u>Florence</u> c. (Last) <u>Strieve</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 24, 1953</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 11 1905</u>		9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Joseph F. Clark</u>			13b. MOTHER'S MAIDEN NAME <u>Mary A. DeHater</u>		14. NAME OF HUSBAND OR WIFE <u>John G. Strieve</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>489-22-3665</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John G. Strieve 6130 Plymouth Ave.</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Cervix with metastases to surrounding areas</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u>		
II. OTHER SIGNIFICANT CONDITIONS: <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>171X</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Dec 26, 1952</u> to <u>April 24, 1953</u> , that I last saw the deceased alive on <u>April 23, 1953</u> , and that death occurred at <u>3:00</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. Dean S. Bean M.D.</u>			23b. ADDRESS <u>35 McCentral St. Louis, Mo.</u>			23c. DATE SIGNED <u>4/25/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/27/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>			
DATE REC'D BY LOCAL REG. <u>4-25-53</u>		REGISTRAR'S SIGNATURE <u>Hester R. Douthett</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Collins Funeral Home 10123 St. Charles Rd.</u>			

P. T. (Licensed Embalmer's Statement on Reverse Side)

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

Dr. Blom #35 No. Central.

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

Sheldon Collier

Licensed Embalmer No. *3382*

P. O. Address. *10123 St. Charles*

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.