

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32031

State File No. _____

FILED OCT 15 1953

4535

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> by COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>1 month</u>		K. c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		g 328 d			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>312 3025 Cleveland</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emma</u> b. (Middle) <u>Belle</u> c. (Last) <u>Stricklen</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 16, 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>Sept. 21, 1898</u>			
9. AGE (In years last birthday) <u>54</u>		10. MONTHS <u>03</u>		10. DAYS <u>25</u>		IF UNDER 1 YEAR Hours _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Independence, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Frank Cline</u>			13b. MOTHER'S MAIDEN NAME <u>Maude L. Becker</u>		14. NAME OF HUSBAND OR WIFE <u>Paul A. Stricklen</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>514-22-1235</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Paul A. Stricklen, Kansas City, Mo.</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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of Breast</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hydrothorax</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1948</u> <u>170X</u>	
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 DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> to <u>Sept 16, 1953</u> , that I last saw the deceased alive on <u>Sept 16, 1953</u> and that death occurred at <u>7 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Philip J. Baker MD</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>4000 Baltimore N.P. Mo</u>		23c. DATE SIGNED <u>9-17-53</u>			
24a. BURIAL CHARGE (If removed, state) <u>BURIAL</u>		24b. DATE <u>9/19/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Independence, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>9-18-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Geo. C. Gerson Independence, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK

25. *01-20-2007*

300 1000

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

La Vega E Brown

Licensed Embalmer No. *4794*

P. O. Address *Independent*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.