

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36747**

FILED NOV 17 1954

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>1</u>	
1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>RANDOLPH</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CAPE GIRARDEAU</u>		c. LENGTH OF STAY (In this place) <u>2 DAYS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHESTER</u>		8/12/9	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>CAPE OSTEOPATHIC HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>221 WALL ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FLORA</u> b. (Middle) <u>ELLEN</u> c. (Last) <u>STRICKLAND</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 10, 1954</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>FEB. 1, 1893</u>		9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
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>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>RICARD PRICE, SR.</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH CRADDER</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN C. STRICKLAND</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John C. Strickland, III</u> ADDRESS <u>CHESTER</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u> ANTECEDENT CAUSES DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS† Conditions contributing to the death but not related to the disease or condition causing death. <u>Possible cause of 2d Injury</u>					INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION: <u>4343H</u>			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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/7</u> , 19 <u>54</u> , to <u>11/10</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11/10</u> , 19 <u>54</u> , and that death occurred at <u>1:01P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>A. T. Schaefer, M.D.</u>				23b. ADDRESS <u>28 S. Sprague St.</u>		23c. DATE SIGNED <u>11-16-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>Nov. 13, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		24d. LOCATION (City, town, or county) (State) <u>CHESTER, ILL.</u>		
DATE REC'D BY LOCAL REG. <u>11-16-54</u>		REGISTRAR'S SIGNATURE <u>C. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. C. Schroeder, Chester, Ill.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

80

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 O. C. Schroeder

Licensed Embalmer No. 1751

P. O. Address Chester Ill.

*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.