

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1349

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
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) 2 1/2		d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		e. STREET ADDRESS (If rural, give location) 1444a Cass Av Rear	

3. NAME OF DECEASED (Type or Print) a. (First) Albert	b. (Middle) F	c. (Last) Strickland	4. DATE OF DEATH (Month) (Day) (Year) Feb 11 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct 20 1869	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber	10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) Colorado	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE May Strickland
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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.	17. INFORMANT'S SIGNATURE OR NAME Clara Grishem	ADDRESS 2861 Arlington Av
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cancer of the Brain</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Sclerosis</i>		
	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 type="checkbox"/>
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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)
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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? <i>193X</i>
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22. I hereby certify that I attended the deceased from *19* to *19*, that I last saw the deceased alive on *19*, and that death occurred at *1244 P* from the causes and on the date stated above.

23a. SIGNATURE <i>Patrick E. Taylor Coroner</i>	(Degree or title)	23b. ADDRESS <i>308 Clark</i>	23c. DATE SIGNED <i>2/14/55</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/14/55	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) St Louis County Mo.
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DATE REC'D BY LOCAL REG. FEB 14 1955	REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Moynell</i>	ADDRESS Funeral Home 1926 Allen Av
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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 Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 4 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.