

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015807

STATE FILE NUMBER
2698

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Phillips Hospital		d. STREET ADDRESS (If outside, give location) 2618 Burd Avenue	
3. NAME OF DECEASED (Type or print) ACEY STRICKLAND		4. DATE OF DEATH Month Day Year March 15, 1959	
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Checker		10b. KIND OF BUSINESS OR INDUSTRY I. C. Railroad	11. BIRTHPLACE (City and state or country) Dyersburg, Tennessee
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Frank Strickland	
13b. MOTHER'S MAIDEN NAME Fannie ?		14. NAME OF HUSBAND OR WIFE Elvira Strickland	
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. 709-23-2615	17. INFORMANT Address Johnnie Mae Quarles 3820a St. Ferd
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO (b) Fracture of the Left Leg DUE TO (c) suffered broken street lamp PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left operated by eye.			19. INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter number of injury in PART I or PART II of this form) Broken street lamp at the intersection of Burd and Green Ave. about 3:35 p.m., March 3, 1959.	
20c. TIME OF INJURY 3:35 p.m. 3 3 59		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 150 Street	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION St. Louis Mo	
21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 12:10 P. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Patrick E. Taylor Coroner		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 3.17.59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/20/59	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Charles J. Gates		25. DATE RECD. BY LOCAL REG. MAR 17 '59	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

mjb

Health, Welfare, Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *Gupton Swan*

Licensed Embalmer No. 4580.....

P. O. Address 4107 Finney Ave.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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