

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015808

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2790**

FILED MAY 8 1959

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson 4109		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Length of stay in lb 4 3/4 hrs	d. STREET ADDRESS (If outside, give location) 1007 Ford Drive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Deborah Middle Kay Last Strickland			4. DATE OF DEATH Month March Day 18 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1959		9. AGE (In years last birthday) IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. 16 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Judson Floyd Strickland		13b. MOTHER'S MAIDEN NAME Zana Mae Willison	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr Judson F. Strickland		Address 1007 Ford Drive			
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Septicemia DUE TO (c) 760.0					INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 45 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 17 March 59 to 18 March 59 and last saw her alive on 17 March 59 Death occurred at 7:40 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) [Signature]			22b. ADDRESS 35 N. Central		22c. DATE SIGNED 18 March 59
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3/19/59		Oak Grove Cemetery	
23d. LOCATION (City, town, or county) (State)				St. Louis Co, Missouri	
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blv			25. DATE RECD. BY LOCAL REG. MAR 19 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature. All diseases in Part I must be causally related.

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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. *Not Embalmed*

Student
Signature of Student Embalmer

Signed *Jos. E. McCullough*

Licensed Embalmer No. *2769*

P. O. Address *6170 1/2 St.*

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.