

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS OCT 8 1959

59-034371

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8922** STATE FILE NUMBER

UNRECORDED

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,		Length of stay in 1b 27 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR St. Louis - Little Rock INSTITUTION Hospitals, Inc.		d. STREET ADDRESS (If outside, give location) 3149 Texas Ave.	
3. NAME OF DECEASED (Type or print) First Myrtle, Middle Marie Last Strain		4. DATE OF DEATH Month September Day 26, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 42
11. BIRTHPLACE (City and state or country) Zalma, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Phillip Deckard		13b. MOTHER'S MAIDEN NAME Lulu Caulder	14. NAME OF HUSBAND OR WIFE Earl Estes Strain
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. Unknown	17. INFORMANT Address Earl E. Strain, 3149 Texas
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <input checked="" type="checkbox"/> a.m. Month, Day, Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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 August 30, 1959 to Sept. 26, 1959 and last saw her alive on Sept. 26, 1959 Death occurred at 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Charles Flower, M.D.		22b. ADDRESS 1755 So. Grand	22c. DATE SIGNED 9-27-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-30-59	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Puxico, Mo.
24. FUNERAL DIRECTOR Morgan Funeral Home - Puxico, Mo.		25. DATE RECD. BY LOCAL REG. SEP 28 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *Robert Haines*
Licensed Embalmer No. 4108

P. O. Address St Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.