

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 26 1960 318 1003 10014 -60-040277 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Mo.</b>	b. COUNTY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Pac. Hosp</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b		d. STREET ADDRESS <b>4039 a McRee</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>James Elroy Strickel</b>			4. DATE OF DEATH Month Day Year <b>October 15-1960</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 5, 1880</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac.R.R.</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Strickel</b>		13b. MOTHER'S MAIDEN NAME <b>Adeline Meredith</b>	
14. NAME OF HUSBAND OR WIFE <b>Hassie W.</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Eullia Frazier 910 E.100 Terr. K.C.M</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	

IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b>		Interval <b>Several months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b>		Interval <b>Several years</b>
DUE TO (c) <b>450.0</b>		

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 type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 a.m. p.m. Month, Day, Year	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 **Aug. 1, 1960** to **Oct. 15, 1960** and last saw <sup>her</sup> him alive on **Oct. 15, 1960**  
Death occurred at **9:50 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Benjamin H. Clark, D.O.</b>	22b. ADDRESS <b>220. No. Hospital - St. Louis</b>	22c. DATE SIGNED <b>Oct. 16, 1960</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>R.R. Removal</b>	23b. DATE <b>10/16/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Utica Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Utica, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>E.J. Schnur 3125 Lafayette Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 16 1960</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 6 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph Willmer

Licensed Embalmer No. 4014  
P. O. Address 2125 Lafayette

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.