

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5995

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri Length of stay in lb 6 Days
 c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 5966 Oakherst Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Illinois b. COUNTY St. Clair
 c. CITY OR TOWN East St. Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1905 McCasland Avenue Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First DAISY Middle _____ Last STROUD 4. DATE OF DEATH Month June Day 24 Year 1961

5. SEX Female 6. COLOR OR RACE Negro 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 4/27/80 9. AGE (last birthday) 81 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Quincy, Illinois 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME LUKE SIDNEY 13b. MOTHER'S MAIDEN NAME AMANDA TUCKER 14. NAME OF HUSBAND OR WIFE NONE

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 William Stroud E. St. Louis, Ill Address 1905 McCasland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 day
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease 1 yr:
 DUE TO (c) 4200

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 1-19-60 to 6-23-61 and last saw her alive on 6-23-61 Death occurred at 2:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. A. Lingal M.D. 22b. ADDRESS 1652 Central Ave. St. Louis, Mo. 62106 22c. DATE SIGNED _____

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 6/30/61 23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens 23d. LOCATION (City, town, or county) (State) Stokey Township, Illinois

24. FUNERAL DIRECTOR Marion's Office ADDRESS 2114 Missouri Ave. E. St. Louis, Illinois 25. DATE RECD. BY LOCAL REG. JUN 28 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Frank Proff

Licensed Embalmer No. 4386

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.