

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039272
STATE FILE NUMBER

AMENDED

Registered District No. **318** Primary Registration District No. **1003** Registrar's No. **9313**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb Life		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute to City Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2108 Lafayette		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MICHAEL Middle DeWAYNE Last STRADER				4. DATE OF DEATH Month 10 Day 7 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/21/60		9. AGE (last birthday) IF UNDER 1 YEAR Months 11 Days 16 IF UNDER 24 HR Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Berry Strader			13b. MOTHER'S MAIDEN NAME Maureen Johnson			14. NAME OF HUSBAND OR WIFE			
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. None		17. INFORMANT Ella Strader, 2102 Lafayette Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Comminuted Fracture of the Skull, involving the left hemisphere with separation at the base; suffered when struck by car operated by one Ralph Camden while deceased was being held by mother on motorcycle in front of about 2245 S. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) See above DUE TO (c) See above							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Jefferson on Oct. 7th, 1961 at approximately 11:10 p.m.						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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) See above					
20c. TIME OF INJURY Hour 11:10 a.m. p.m. Month, Day, Year 10-7-61		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 23 Street		20f. CITY, TOWN, OR LOCATION St. Louis, Mo		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 11:29 P m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Nelen L. Taylor, Corona					22b. ADDRESS 1300 Clark Ave.		22c. DATE SIGNED 10-9-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/11/61	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.		23d. LOCATION (City, town, or county) St. Louis, Mo.		(State)		
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette				25. DATE RECD. BY LOCAL REG. OCT 9 1961		26. REGISTRARS SIGNATURE Roan Smith, M.D.			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

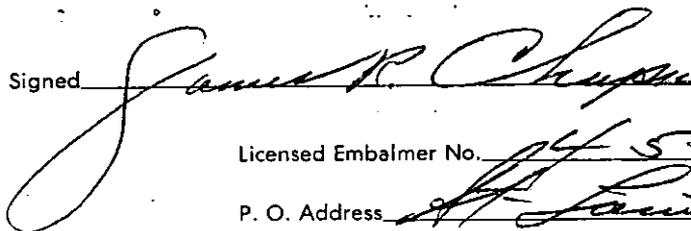
BY AFFIDAVIT OF

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  _____
Licensed Embalmer No. 445
P. O. Address H. L. Linn

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.