

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041180

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3142

FILED NOV 5 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>St. Louis</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> Length of stay in lb</p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DOA County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u></p> <p>c. CITY OR TOWN <u>Meacham Park</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>236 Alsobrook</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED First <u>James</u> Middle <u>Strickland</u> Last <u>Strickland</u></p>	
<p>4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1962</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>Negro</u></p>
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>1-2-1890</u> 9. AGE (last birthday) <u>72</u></p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u></p>	<p>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u></p>
<p>11. BIRTHPLACE (City and state or country) <u>Mount Olive Miss.</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>Unknown</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Unknown</u></p>
<p>14. NAME OF HUSBAND OR WIFE <u>Odessa Strickland</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <u>No</u></p>
<p>17. INFORMANT <u>Odessa Strickland 236 Alsobrook</u></p>	<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized + Cerebral Arteriosclerosis</u></p> <p>DUE TO (c) <u>unknown</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary occlusion + infarct</u></p> <p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour <u>5:30 a.m.</u> Month, Day, Year <u>10/8/62</u></p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>	
<p>21. I attended the deceased from <u>10/8/62</u> to <u>10/27/62</u> and last saw him alive on <u>10/16/62</u></p> <p>Death occurred at <u>(D.S.T.) 5:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.</u></p>	
<p>22a. SIGNATURE (Degree or title) <u>G.H. Barnett M.D.</u></p>	<p>22b. ADDRESS <u>10824 Grandchester Rd, Kirkwood, Mo.</u></p>
<p>22c. DATE SIGNED <u>10/27/62</u></p>	<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>
<p>23b. DATE <u>10-31-1962</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cemetery</u></p>
<p>23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u></p>	<p>24. FUNERAL DIRECTOR <u>E.B. Hodson</u> ADDRESS <u>1221 N. Grand Blvd</u></p>
<p>25. DATE RECD. BY LOCAL REG. <u>10-29-62</u></p>	<p>26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u></p>

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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

Melvin Blackburn

Licensed Embalmer No. 3962

P. O. Address 1221 N Grand Ave

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.

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