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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 5 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36469

Registrar's No. 10118

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Abt. 8 hours (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4234 a West Belle Place
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country ---

3. (a) PRINT FULL NAME LEE STRAYHORN

3. (b) If veteran, name war ---

3. (c) Social Security No. 500-18-0406

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Pearl Strayhorn

6. (c) Age of husband or wife if alive Abt. 50 years

7. Birth date of deceased March 13, 1898
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
46	8	9	-- hr. -- min.

9. Birthplace Jackson, Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business Resturant and Tavern

FATHER
12. Name Sandy Strayhorn
13. Birthplace Unavailable Georgia
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Hannah Unavailable
15. Birthplace Unavailable Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Oscar Strayhorn
(b) Address 3666 Finney Avenue

17. (a) Burial (b) Date thereof 11/28/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Avenue

19. (a) NOV 28 1944 (b) [signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22nd
year 1944 hour 7: minute 55 A.M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h. alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Acute Generalized Diffuse Peritonitis, Contrib. Perforated Gastric Ulcer.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury 3

23. Signature Thomas F. Cullinan Coroner (M. D. or other)
Address 1300 Clark Avenue Date signed 11/28/44

(Licensed Embalmer's Statement on Reverse Side)

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 Thomas J. Gates, Registered Apprentice No. _____, working under my personal supervision.

Signed Thomas Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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 this body is not embalmed, fact should be so stated above.