

FILED MAY 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14784
2861

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>	c. LENGTH OF STAY (in this place) <u>3-22-51</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES 4607</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>122 CENTRAL AVE</u>	

3. NAME OF DECEASED (Type or Print) <u>WILLIAM FRANCIS STRAIN</u>			4. DATE OF DEATH <u>MAR-27-1951</u>		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR. 1-1883</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR	IF UNDER 1 YEAR	IF UNDER 1 YEAR
					Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE-MANAGER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FRISCO. R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>GREENVILLE ILL.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>WILLIAM STRAIN</u>	13b. MOTHER'S MAIDEN NAME <u>FANNIE RODGERS</u>	14. NAME OF HUSBAND OR WIFE <u>ELIZABETH STRAIN</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>702-07-9675</u>	17. INFORMANT'S SIGNATURE OR NAME <u>DOROTHY WOLF</u>	ADDRESS <u>122 Central</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u>			<u>1/2 hr</u>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	DUE TO (b) <u>Coronary insufficiency</u>		<u>1 year</u>
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from February 5, 1950, to March 27, 1951, that I last saw the deceased alive on Mar 27, 1951, and that death occurred at 7:30 m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. M. Maccubbin md.</u>	(Degree or title)	23b. ADDRESS <u>3701 Grandel St</u>	23c. DATE SIGNED <u>3-27-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MAR-29-1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PK.</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MAR 27 1951</u>	REGISTRAR'S SIGNATURE <u>L. B. Lassiter</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker - Aldrich Funeral Home</u>	ADDRESS <u>Webster Groves</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Leslie Walsh

Licensed Embalmer, No. *4395*

P. O. Address *Abolater Grove*

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.