

FILED MAR 15 1954 THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6868

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2185**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		e. STREET ADDRESS (If rural, give location) 5400 Arsenal St.	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) EDWARD	b. (Middle) C.	c. (Last) STRICKLAND	(Month) March (Day) 5, (Year) 1954.
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 7/19/75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Painter		De Soto Mo.	
11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY	
De Soto Mo.		U.S.A.	

13a. FATHER'S NAME James Strickland	13b. MOTHER'S MAIDEN NAME Caroline Md. Mullen	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 date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Hospital Records

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 mos. x
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Prostate		
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. 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"/>
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)
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? 177 X

22. I hereby certify that I attended the deceased from **Sept 1, 1953**, to **March 5, 1954**, that I last saw the deceased alive on **March 5, 1954**, and that death occurred at **11:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>W.D. [Signature]</i>	(Degree or title) N.D.	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 3/7/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-9-54	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. MAR 9 1954	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Shepard</i>	ADDRESS Funeral Home, 1167 Hamilton
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Merle Shepard
Embalmer

Licensed Embalmer No.....

P. O. Address

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING
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.