

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42855

FILED DEC 17 1954

11273

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

1. PLACE OF DEATH a. COUNTY Missouri				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. LENGTH OF STAY (In this place) 10 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital				d. STREET ADDRESS (If rural, give location) 12 5351 Delmar 0			
3. NAME OF DECEASED (Type or Print) a. (First) Ellen b. (Middle) Louise c. (Last) Strong			4. DATE OF DEATH (Month) 12 (Day) 9 (Year) 1954				
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH Sept. 3. 1879		9. AGE (In years last birthday) 75	10. IF UNDER 1 YEAR B	11. IF UNDER 24 HRS. 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Vail, Iowa		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Albert L. Strong		13b. MOTHER'S MAIDEN NAME Mary DeWolf		14. NAME OF HUSBAND OR WIFE unmarried			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Masonic Home of Missouri, 5351 Delmar Lewis Robinson Supt.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		18. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Vascular Renal Disease  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 3 1/10.  2 Yrs
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 442X			
22. I hereby certify that I attended the deceased from 3-28, 1954, to 12-9, 1954 that I last saw the deceased alive on 12-9, 1954 and that death occurred at 4:5P m., from the causes and on the date stated above.							
23. SIGNATURE (Degree or title) John Cairns M.D.				23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 12-9-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-10-54	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Savannah, Mo.		
DATE REC'D BY LOCAL REG. DEC 10 1954		REGISTRAR'S SIGNATURE Carl Smith M.D. mjb		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Albert H. Hoppe 4700 Washington.			

(Licensed Embalmer's Statement on Reverse Side)

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

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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 embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo

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.