URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959

59-041420
STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 285

AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: St Charles
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St Charles — Length of stay in Ib: 40 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 1301 No. 4th St — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: St Charles
c. CITY OR TOWN: St Charles — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1301 No. 4th St — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Emma — Middle: C. — Last: Strait
4. DATE OF DEATH: Month, Day, Year: Found Nov. 22 - 59
5. SEX: Female
6. COLOR OR RACE: White
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH: 3/3/1868
9. AGE (last birthday): 91 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St Charles Mo
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mrs Ed Smith St Louis Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): EVIDENTLY NATURAL CAUSES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): DEP. CORONER NOTIFIED 11/23/59
DUE TO (c): (NO INQUEST)
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at FOUND DEAD m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Marcella Wilson L. Reg.
22b. ADDRESS: 902 Holly St Charles
22c. DATE SIGNED: 11/24/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/25/59
23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
23d. LOCATION (City, town, or county) (State): St Charles Mo.

24. FUNERAL DIRECTOR — ADDRESS: Arthur C Baue St Charles Mo.
25. DATE RECD. BY LOCAL REG.: Nov. 24-59
26. REGISTRAR'S SIGNATURE: Marcella Wilson

(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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.