

# FEDERAL BUREAU OF INVESTIGATION FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 14 1960

53

Primary Registration District No. 3009

Registrar's No. 106

-60-005423

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cape Girardeau</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence 217 N. East</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Gir</u> c. CITY OR TOWN <u>Jackson Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>217 N. East</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Henry</u> Middle <u>John</u> Last <u>Strickert</u>			<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>9</u> Year <u>1960</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4/9/1885</u>	<b>9. AGE</b> (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Minister of Gospel</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Ontario Canada</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u>		<b>13a. FATHER'S NAME</b> <u>Friedrik Strickert</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Cathrine Neumann</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Minne Strickert</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>486-42-5493-A</u>			
<b>17. INFORMANT</b> <u>Mrs. H. J. Strickert</u>		<b>17. INFORMANT</b> Address <u>Jackson Mo.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>April 1956</u> to <u>3-9-60</u> and last saw <sup>her</sup> him alive on <u>Feb. 4, 1960</u> Death occurred at <u>9:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>C.F. McDonald, M.D.</u> (Degree or title)			<b>22b. ADDRESS</b> <u>Jackson, Mo.</u>		<b>22c. DATE SIGNED</b> <u>3-10-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>3-12-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Russell Heights</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Jackson Mo</u> (State) _____			
<b>24. FUNERAL DIRECTOR</b> <u>McCombs</u> ADDRESS <u>Jackson Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>3-12-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Irene Karter</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Bruce Dockins, Student Embalmer No. 598

working under my personal supervision.

Student Bruce Dockins  
Signature of Student Embalmer

Signed BA Meyer

Licensed Embalmer No. 3057

P.O. Address Jackson

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