LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 791 File No. 36182
Primary Registration District No. 1003 Registered No. 9551

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County
Township or Village or City St Louis Mo (No. City Hospital St. 8 Ward)
868
2 FULL NAME Frank Stroecker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July (Month) 12 (Day), 1890 (Year)

7 AGE 28 yrs. 3 mos. 1 ds.
If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Lab.
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) St. Louis, Mo.

PARENTS
10 NAME OF FATHER Wm Stroecker
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto O. Spitzer
(Address) City Hospital

15 Filed OCT 14 1918, 191 Mark Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

2

16 DATE OF DEATH Oct (Month) 13 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 12, 1918, to Oct 13, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:
Influenza
11A
10A (Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Broncho-pneumonia
(Duration) ....yrs. ....mos. ....ds.
(Signed) Chas A. Kern M. D.
Oct 14, 1918 (Address) City Hospital

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ....yrs. ....mos. 2 ds. In the State 28 yrs. 3 mos. 1 ds.
Where was disease contracted if not at place of death? Webster Groves
Former or usual residence Webster Groves Mo

19 PLACE OF BURIAL OR REMOVAL Oak Hill
DATE OF BURIAL Oct 15, 1918

20 UNDERTAKER Parkerlund Co
ADDRESS Webster Groves

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ..... (Month) ..... (Day) ..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15 .....

Filed ....., 191....., ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ..... (Month) ..... (Day) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS