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

Do not use this space.

42759

1. PLACE OF DEATH
County Lutheran Hospital — Registration District No. 791
Township St. Louis, Mo. — Primary Registration District No. 1003
City St. Louis (No. Lutheran Hospital St. Ward)

File No.
Registered No. 12547

2. FULL NAME Baby Strickler
(a) Residence. No. 1646 S. Theresa St., 17 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-24-29

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, 7 hrs. or 46 min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Robert Strickler
11. BIRTHPLACE OF FATHER (CITY OR TOWN) N. Manchester Ind.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Adelle Dorrance
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) De Soto Mo.
(STATE OR COUNTRY)

14. INFORMANT Robert Strickler
(Address) 1646 S Theresa Ave

15. FILED DEC 26 1929 Max C Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/25 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/24, 1929, to 12/25/29, 19..., that I last saw him alive on 12/24/29, 19..., and that death occurred, on the date stated above, at 3:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prematurity
15 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 16 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical & Clinical Tests
(Signed) W H Walters, M. D
12/25, 1929 (Address) 3608 S Gd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hovine Mo
DATE OF BURIAL: Dec 26 1929

20. UNDERTAKER: Clement Und Co S Grand Bould
ADDRESS 2217

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.