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

Do not use this space.

28307

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 8159

City St Louis Mo (No. 5571 Cabanne St. ..... Ward)

2. FULL NAME Henry Strauss

(a) Residence. No. 5571 Cabanne, 5 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/7/1848

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired 10 yrs
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Bookkeeper

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Italy

PARENTS

10. NAME OF FATHER Morris Strauss

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Regina Ellen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

14. INFORMANT Lilly Strauss
(Address) 5571 Cabanne

15. FILED AUG 15 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Aug 13, 1930 that I last saw him alive on Aug 12, 1930, and that death occurred, on the date stated above, at 10 m. 2 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio sclerosis
(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chr. myocarditis
(duration) 2 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? .....

(Signed) [signature], M.D.
8/15, 1930 (Address) 1727 Lafayette

*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	DATE OF BURIAL
Mt Sinai	Aug 15 1930
20. UNDERTAKER	ADDRESS
Mayer	4358 Lindell

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.

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