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

Do not use this space.

7343

File No. .....

Registered No. 1658

1. PLACE OF DEATH

County ..... Registration District No. 1794 1002

Township ..... Primary Registration District No. .....

City St Louis (No. Mo Baptist Hospital St. ..... Ward)

2. FULL NAME Charles D. Strecker

(a) Residence. No. 6800 St Louis Ave St., 12 Ward. St. Louis Co. Mo.
(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	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 Anna Strecker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16, 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	0	21	

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

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

PARENTS

10. NAME OF FATHER Lee Strecker

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

12. MAIDEN NAME OF MOTHER Barbara Hammon

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

14. INFORMANT Mrs Anna Strecker
(Address) 6800 St. Louis Ave

15. FILED FEB 10 1931, 19 Day C Hankins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1931

17. I HEREBY CERTIFY, That I attended deceased from 1/29/31, 19..., to 2/7/31, 19..., that I last saw him alive on 2/7/31, 19..., and that death occurred, on the date stated above, at 1:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Strangulated Left inguinal hernia
K470/A
170 (duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (SECONDARY) Peritonitis (Acute)
(duration) ..... yrs. ..... mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? yes DATE OF 1/29/31
WAS THERE AN AUTOPSY? yes.
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy findings
(Signed) E. E. Tenuick M. D.
, 19 (Address) 3532 Washington

*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
Lake Charles Cem.	2-10 1931
20. UNDERTAKER	**ADDRESS**
Geo L. Pleitsch	5966 Easton Ave

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

Dr [illegible]

3532 Washington [illegible]

11 [illegible] 1