

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

Do not use this space.

MAY 2

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. **791**
1003
Primary Registration District No. *Palmer*

File No. **14610**
Registered No. **3796**
St. Ward)

2. FULL NAME

(a) Residence, No. *4919 Palmer* St., *6* Ward.

(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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *May 11, 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
43 11 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Subintendent*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Cigar Box Factory*
10. Date deceased last worked at this occupation (month and year) *Oct 10, 1934* 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

MOTHER FATHER 13. NAME *August Stratman*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*

MOTHER 15. MAIDEN NAME *Elizabeth*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT *Anna Stratman*
(ADDRESS) *4919 Palmer St.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Paul United Chh. DATE April 16, 1934*

19. UNDERTAKER *Heiderly & Co. Funeral Home Inc.*
(ADDRESS) *1936 St. Louis Ave.*

20. FILED *44 16 1934* *J. F. Bredeck*
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 13, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 15, 1934* to *April 13, 1934*
I first saw h.c.m. alive on *April 13, 1934*. Death is said to have occurred on the date stated above, at *8:00 A.M.*

The principal cause of death and related causes of importance were as follows:

Chronic Tuberculosis Date of onset *1923*
acute
subacute
subacute *1/15/34*

Name of operation..... Date of.....
What test confirmed diagnosis? *any* Was there an autopsy? *No.*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?.....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify.....
(Signed) *W. H. ...* M. D.

(Address) *3103 ...*

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.

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