

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.

9071 1937

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

32847

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **4003 Lexington Avenue** Registered No. **8901**
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

EVA STRUNCK,
(a) Residence, No. **4003 Lexington Avenue** St. **JD** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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 **William H. Strunck**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 6, 1873**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
64 6 16
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

13. NAME **Michael Roth**

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

15. MAIDEN NAME **Barbara Schaefer**

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

17. INFORMANT (ADDRESS) **William H. Strunck**
4003 Lexington Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE **Bethany** DATE **Sept. 25, 1937**

19. FUNERAL DIRECTOR (ADDRESS) **Math. Hermann & Son**
2161 East Fair Avenue

20. **SEP 24 1937** **J. H. Bradeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 22, 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Sept 14**, 19**37**, to **Sept 22**, 19**37**
I last saw him alive on **Sept 21**, 19**37** Death is said to have occurred on the date stated above, at **12:00 Noon**
The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation **none** Date of
What test confirmed diagnosis? **syphilis** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? **none** Date of injury, 19.....
Where did injury occur? **none** (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **none**
Nature of injury **none**

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **no**
(Signed) **Dr. J. F. Hammann** M. D.
(Address) **2743 N. Grand**

STATEMENT BY LICENSED EMBALMER

I, William G. Buchholz, Licensed Embalmer No. 2110

hereby certify that the body recorded on the reverse side of this certificate was embalmed by William G.

Buchholz, L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed William G. Buchholz

Licensed Embalmer No. 2110

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)