

REC'D JUL 12 1939

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

791  
1003

20138  
Do not use this space.

Registered No. 4982

1. PLACE OF DEATH

(a) County..... 2 Registration District No.....  
(b) Township..... Primary Registration District No.....  
(c) City St. Louis / (d) Street No. 4349 Delor  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William L. Strobel

(a) Residence, No. 4349 Delor St.  (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 26 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	72	2	5	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Solicitor  
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) St. Joe  
(STATE OR COUNTRY) Indiana

13. NAME Jacob Strobel

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Nora Hanses  
(ADDRESS) 4349 Delor

18. BURIAL, CREMATION, OR REMOVAL PLACE New St. Marcus DATE June 3 39

19. FUNERAL DIRECTOR (NAME) Schumacher Und. Co.  
(ADDRESS) 3013 Meramec

20. FILED JUN 1 1939 J.B. Budek  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 31, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 10, 1938 to May 31, 1939  
I last saw him alive on May 31, 1939 Death is said to have occurred on the date stated above, at 10:55 A.M.  
The principal cause of death and related causes of importance were as follows:

Chronic Endocarditis 1938  
Chronic Ductectasia 1939  
nephritis  
Other contributory causes of importance: Acute Carditis  
Scleratitis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) Adam G. Gorman, M. D.  
(Address) 5439 Gravois

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.

5139 Elements  
Ri 1340  
1-3

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

*Clarence Kochow*

Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Clarence Kochow*

Licensed Embalmer No. ....

*3093*

P. O. Address.....

*3013 Miram*

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.)

If this body is not embalmed, above space should be left blank.