

No. 2  
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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH

14117

FILED MAY 20 1942

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 115

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City Mo.

(c) Name of hospital or institution: St. Marys Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 days  
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Mary Bernadine Struempfl

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 1

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Feb 10 1876  
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Kaeltztown Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Wm. Schwarze

13. Birthplace Westphalia Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Heleman

15. Birthplace Westphalia Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant John Struempfl

(b) Address St. Elizabeth's Mo.

17. (a) General - Burial (b) Date thereof 5-10-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Elizabeth's Mo.

18. (a) Signature of funeral director Norma Peltier

(b) Address Mo.

19. (a) 5-7-42 (b) Norma Peltier  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miller 66

(c) City or town St. Elizabeth Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1942 hour 10 minute 25 A.M.

21. I hereby certify that I attended the deceased from Apr 7 1942 to May 7 1942 that I last saw her alive on May 7 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to \_\_\_\_\_

Due to Fracture Left femur

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 5-10-42

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J.A. Cassman (M. D. or other) MD

Address Jefferson City Date signed 5-7-42

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Herman H. Strop*

Licensed Embalmer No.....

*2924*

P. O. Address.....

*Metz MD*

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 14117  
Registrar's No. \_\_\_\_\_

Registration District No. 213 Primary Registration District No. 3014

1. PLACE OF DEATH:  
(a) County Cole  
(b) City or town Jesserson city  
(c) Name of hospital or institution \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary B Struempfl  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May Day 23 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced in  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Feb 10 1875  
(Month) (Day) (Year)

Fracture of left femur  
Due to April 6, 1942 @ home  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 65 Months 2 Days 10 If less than one day \_\_\_\_\_ min.  
9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

1860  
18  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall  
23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

