

Registration District No. 276

Primary Registration District No. 5947

Registrar's No. _____

1. PLACE OF DEATH

(a) County Phelps
(b) City or town St James - Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Soldiers Home Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital, or institution 5 1/2 years
(Specify whether years, months or days)
In this community 5 1/2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Phelps
(c) City or town St James 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? A years.

3. (a) PRINT FULL NAME

Mary E. Straube

3. (b) If veteran, name war L

3. (c) Social Security No. L

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced W

6. (b) Name of husband or wife Christian Straube 6. (c) Age of husband or wife if alive - years 8 - 1861

7. Birth date of deceased OCT 8 - 1861
(Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 7 If less than one day hr. min.

9. Birthplace Greenview Ill
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name don't know

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant Soldiers Home Office
(b) Address St James MO

17. (a) Removal (b) Date thereof 1-17-44
(Burial, cremation, or disposal) (Month) (Day) (Year)

(c) Place: burial or cremation Belleisle Cell

18. (a) Signature of funeral director W. E. Lieblich
(b) Address St James MO
19. (a) 1-1-1944 (b) Chas. Dickson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1
year 1944 hour 6:50 minute _____ M.

21. I hereby certify that I attended the deceased from Dec 20, 1943 to Jan 1, 1944
that I last saw her alive on Dec 31, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 33a

Major findings: Of operations _____
Of autopsy _____

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 _____

23. Signature William H. Green M. D. or other _____
Address St James MO Date signed 1/1/44

Duration

10 days

PHYSICIAN

Underlines the cause to which death should be charged statistically.

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

1091

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 _____

_____ *me* _____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Oral E. Liebkolder

Licensed Embalmer No. _____

3546

P. O. Address _____

St James mo

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.