V. S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 19 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19262

Registration District No. 318 Primary Registration District No. Registrar's No. 5092

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Anthony's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 Days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1237 S. 14th.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ned Strosnider
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex M
5. Color or race W.
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 31 (Day) 19 45 (Year)

8. AGE: Years x Months x Days 8 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Infant
11. Industry or business
FATHER
12. Name Joe Strosnider
13. Birthplace Alton (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Pauline Andrews
15. Birthplace Alton (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Joe Strosnider
(b) Address 1237 S. 14th.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/9/45 (Month) (Day) (Year)
(c) Place: burial or cremation Alton Mo.
18. (a) Signature of funeral director A. W. McLaughlin
(b) Address 2301 Lafayette
19. (a) JUN 9 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 1945 hour 7 minute 00 A. M.
21. I hereby certify that I attended the deceased from June 1, 1945, to June 7, 1945
that I last saw him alive on June 7, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to Pre-Mature	5 wk
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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
(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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature H. G. Moore (M. D. or other)
Address 921 5018 Date signed 6-8-45

(Licensed Embalmer's Statement on Reverse Side)

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

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.