J. S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 11 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

22623

State File No. 6834

Registration District No. 818 Primary Registration District No. 2003 Registrar's No.

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

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1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3525 Ohio Ave 9 24
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Strauss

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Mary

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

7. Birth date of deceased Oct (Month) 6 (Day) 1871 (Year)

8. AGE: Years 73 Months 9 Days 4 If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Martin Strauss
13. Birthplace (City, town, or county) Georgia 1 (State or foreign country)

MOTHER
14. Maiden name Carrie Pellum
15. Birthplace (City, town, or county) Tenn 1 (State or foreign country)

16. (a) Informant Wm E Strauss Jr
(b) Address 3525 Ohio Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug (Month) 6 (Day) 1945 (Year)
(c) Place: burial or cremation New S. S. Peter & Paul

18. (a) Signature of funeral director Thomas Kuhs & Son
(b) Address 2906 Gravois Ave

19. (a) AUG 3 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 2nd year 1945 hour 3:50 minute P. M.

21. I hereby certify that I attended the deceased from , 19 , to 8/2/45 , 19 ; that I last saw him alive on 8/2/45 , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure

Due to Coronary sclerosis advanced

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Inc. Incisional hernia

Of autopsy Broncho pneumonia of the lower lobes of the lungs

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

(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 Peter Thomas (M. D. or other)

Address 1515 Lafayette Date signed 8/2/45

(Licensed Embalmer's Statement on Reverse Side)

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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 2906 Gravois Ave

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.