S. No. 2
M—8-43
. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27341

Registration District No. 119 Primary Registration District No. 4192 Registrar's No. 4

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

37
0
0

1. PLACE OF DEATH:

(a) County GASCONADE

(b) City or town MORRISON (Richland)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: HOME 1
(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 MISSOURI (b) County GASCONADE 37

(c) City or town MORRISON 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME GEORGE WM STRECK

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

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

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of ~~husband~~ or wife ELISABETH

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased FEB (Month) 27 (Day) 1865 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	6	18	..... hr. ..... min.

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

10. Usual occupation Retired Laborer

11. Industry or business .....

FATHER
12. Name NOT Known
13. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name NOT KNOWN
15. Birthplace NOT KNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant C. G. Streck 1
(b) Address Morrison Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-45 (Month) (Day) (Year)

(c) Place: burial or cremation Morrison Mo

18. (a) Signature of funeral director Arnold Immel
(b) Address Morrison Mo

19. (a) Aug. 10/45 (Date received local registrar) (b) A. H. Siedler (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month AUGUST day 9TH
year 1945 hour 4 minute 45 A.M.

21. I hereby certify that I attended the deceased from 8/9/1945
1 ....., 19..., to 8/9/1945, 19...;
that I last saw him alive on 8/9/, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CIRCULATORY FAILURE	MINUTES
Due to MYOCARDIAL INSUFFICIENCY	INDEFINITE
Due to ARTERIOSCLEROSIS + SENILITY	YEARS

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 Carl E. von Bastian (M. D. or other) DO

Address Morrison Mo. Date signed 8/9/45

1261 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 9-6-45

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 Otto Stvaksick

Licensed Embalmer No. 1902

P. O. Address Chamois 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, fact should be so stated above.