

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** JUN 3 1946  
Registration District No. 3/7

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 6076

18114  
State File No. 1148  
Registrar's No.

**1. PLACE OF DEATH:**

(a) County St. Louis  
(b) City or town Jefferson Barracks  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Veterans Administration Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether  
In this community 59 Years  
years, months or days)

3. (a) PRINT **STRAEDEY, Frank Leo**  
FULL NAME

3. (b) If veteran, name war World I 3. (c) Social Security No. 495227695

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased December 21 1886  
(Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days 4 If less than one day  
hr. min.

9. Birthplace De Soto, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Porter

11. Industry or business

12. Name Frank Straedy  
13. Birthplace France  
(City, town, or county) (State or foreign country)  
14. Maiden name Lindine Callard  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk, Vet. Adm. Hosp.  
(b) Address Jefferson Barracks, Missouri  
17. (a) Burial (b) Date thereof May 27, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New SS. Peter & Paul Cem.  
18. (a) Signature of funeral director C. Hoffmeister Colonial Mortuary  
(b) Address 6464 Chippewa st.  
19. (a) 5-27-46 (b) E. H. Sarant  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4302 Ashland Avenue  
(If rural, give location)  
(e) Citizen of foreign country? Unknown (Yes or No)  
If yes, name country.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 25  
year 1946 hour 5:45 minute A M.

21. I hereby certify that I attended the deceased from 5/24/46 19   to 5/25/46 19  ;  
that I last saw him alive on May 25 19   46  
and that death occurred on the date and hour stated above.

Immediate cause of death MYOCARDITIS & PULMONARY EDEMA UNK

Due to 93  
Due to

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations No Operation  
Of autopsy No Autopsy

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) No  
(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 St. Louis (Specify type of place) Means of injury     
23. Signature L. E. STILWELL, M.D. (M. D. or other)  
Vet. Adm. Hosp. Jeff. Brks. Date signed 5/25/46  
Address

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**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..... *Leona C. Hoffmeister* .....

Licensed Embalmer No. *3871* .....

P. O. Address *7814 S. Broadway* .....

**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.**