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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40309**

FILED JAN 9 1947
128

Registration District No. _____

Primary Registration District No. **5466**

Registrar's No. **1055**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **S. Campbell Twp., Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 month, 8 days**
1 month, 8 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **New York** (b) County **Kings** **977**
(c) City or town **Brooklyn**
(If outside city or town limits, write "RURAL") **3**
(d) Street No. **8210 19th Avenue**
(If rural, give location) **9**
(e) Citizen of foreign country? **No** (Yes or No) **2**
If yes, name country _____

3. (a) PRINT FULL NAME **David STROHL #5906-H**

3. (b) If veteran, name war **World War II** 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 **Ruth Frost Ellis** 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased **September 18 1922**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	24	3	13	hr. min.

9. Birthplace **Brooklyn New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **diamond cutter**

11. Industry or business _____

12. Name **Simon Strahl**

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

14. Maiden name **Sophie Schildkraut Strahl**

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

16. (a) Informant **File**

(b) Address **MCFP 1/2/47**

17. (a) **Removal** (b) Date thereof **XXXXXX**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New York New York**
ALMA LOHMEYER FUNERAL HOME

18. (a) Signature of funeral director **Springfield, Missouri**

(b) Address **Springfield, Missouri**

19. (a) **1-2-47** (b) **N.S. Handrym D**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **31**
year **1946** hour **6:22** minute **A.** M.

21. I hereby certify that I attended the deceased from **November 23**, 1946, to **December 31**, 1946, and that death occurred on the date and hour stated above. **December 31**, 1946

Immediate cause of death **Dementia praecox, hebephrenic type but also with catatonic symptomatology**

Duration **Approx. 3 mo.**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations **S4B**
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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **E.W. Morland** (M. D. **XXXX**)
Address **U.S. Medical Center, Springfield, Missouri** Date signed **1-2-47**

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

MOTHER FATHER

JAN 8 1948

NOV 22 1948

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. A. Roof

Licensed Embalmer No. 3044

P. O. Address..... Springfield, 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.