

FILED MAY 1 467 1947 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **4067**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(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
(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

3. (a) PRINT FULL NAME **JOSEPH STRANAD**
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 **U.K.** **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased: **U.K.** (Month) _____ (Day) _____ (Year) _____

8. AGE **Not 67** Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: **CZECHOSLOVAKIA** (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation: **U.K.**

11. Industry or business: _____

MOTHER FATHER

12. Name: **U.K.**
13. Birthplace: _____ (City, town, or county) _____ (State or foreign country) _____
14. Maiden name: **U.K.**
15. Birthplace: _____ (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant: **Mrs. J. Neill**
(b) Address: **2331 Mullamphd**
17. (a) (Burial, cremation, or removal): **BURIAL** **(b) Date thereof:** **11-19-47** (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation: **CALVARY**

18. (a) Signature of funeral director: **William K. Gillo**
(b) Address: **1386 Lindbergh**
19. (a) APR 19 1947 (Date received local registrar) _____ **(b) J. J. J. J. J.** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **23**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **1011 W. Boulevard** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **4th** year **1947** hour **7:00** minute _____ P. M.
21. I hereby certify that I attended the deceased from **1/20/47**, 19____, to **April 4th**, 19____
that I last saw h **im** alive on **April 4th**, 19____ and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary artery heart disease**
Due to: **Myocardial Infarction, old**
Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: **9H**
Of operations: _____
Of autopsy: **As above**

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? _____
What at _____ (Specify time of place) _____ of injury _____
Signature **John E. Koch** 1515 Lafayette 4/5/47 (Date signed)

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.....

Tom Carter

Registered Apprentice No. *500*

working under my personal supervision.

Signed

Albert G. Koppa

Licensed Embalmer No. *2971*

P. O. Address.....

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.