

No. 2
1-747
5-17-39

National Office of Vital Statistics
FILED MAY 1 1948
Registration District No. _____

Primary Registration District No. _____

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: Josephine Hosp.
(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 St. Louis
(c) City or town Mattese
(If outside city or town limits, write "RURAL")
(d) Street No. Mattese School Rd.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Robert Strobl Jr.
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, Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased..... April 19 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 hr. min.

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

10. Usual occupation None

11. Industry or business.....

12. Name Robert Strobl

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

14. Maiden name Beatrice Mueller

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

16. (a) Informant Robert Strobl

(b) Address Mattese Mo.

17. (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mattese Mo.

18. (a) Signature of funeral director Fendler Und. Co.

(b) Address 7420 Michigan Ave

19. (a) 422-21-1845 (b) J.F. Brebeck
(Date of death) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20 year 1947
hour 8 minute 45 A.M.

21. I hereby certify that I attended the deceased from April 19 1947 to April 20 1947
that I last saw him alive on April 20 1947
and that death occurred on the date and hour stated above.
Duration

Immediate cause of death
Chronic failure
parted at hepatic hilum
patent ductus arteriosus
patent foramen ovale

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
157

PHYSICIAN
Underline the cause of 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)
(e) Means of injury.....

23. Signature [Signature] (M. D. or other)

Address 1702 A. Street Date signed 4-21-47

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

MOTHER FATHER

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 _____

Oliver E. Padden

Licensed Embalmer No. 4148

P. O. Address Jenney

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.