

FILED NOV 20 1947

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 369

1. PLACE OF DEATH:

(a) County Callaway
 (b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
State Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 31 yrs 11 mo 22 days
(Specify whether years, months or days)
 In this community 31 yrs 11 mo 22 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 14
 (c) City or town Kennett City 6
(If outside city or town limits, write "RURAL")
 (d) Street No. OK
(If rural, give location)
 (e) Citizen of foreign country? Not known (Yes or No)
 If yes, name country _____ 10

3. (a) PRINT FULL NAME JOHN STREBLEIN

3. (b) If veteran, name war OK 3. (c) Social Security No. 20 me

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 OK DK 1864(1)
(Month) (Day) (Year)

8. AGE: Years 83 Months DK Days OK If less than one day _____ hr. _____ min.

9. Birthplace OK Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Stone Mason

11. Industry or business Stone Mason

MOTHER FATHER

12. Name OK

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

14. Maiden name OK

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

16. (a) Informant Hospital Records State Hospital

(b) Address Fulton, Missouri

17. (a) Removal (b) Date thereof 10 20 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia and J. O. Roberts

18. (a) Signature of funeral director Columbia Mo

(b) Address _____
 19. (a) 10-20-1947 (b) Joie Moravskoff
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14
 year 1947 hour 12:50 minute P M.

21. I hereby certify that I attended the deceased from January 1
1946 to October 14 1947
 that I last saw him alive on Oct 14 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to _____

Due to _____

Other conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 13 B

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 P

23. Signature Dr. R. P. Price M.D.
(In the presence of _____ M.D. or other)

Address State Hospital No. 1 Date signed 14 Oct 47
Fulton, Mo.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 3,
District File Number
Date Filed NOV 19 1947

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.....

Licensed Embalmer No.....

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.