No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JAN 30 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 3133

Registrar's No. 498

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4020 Laclede Ave. 18 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Maurice Strain
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Infant 1
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January (Month) 11 (Day) 1948 (Year)

8. AGE: Years 0 Months 0 Days 4 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)
10. Usual occupation None
11. Industry or business

MOTHER FATHER
12. Name Carl Strain
13. Birthplace Kaw City (City, town, or county) Oklahoma 1 (State or foreign country)
14. Maiden name Imogene Clark
15. Birthplace Puxico (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Carl Strain
(b) Address 4020 Laclede Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-48 (Month) (Day) (Year)
(c) Place: burial or cremation Wayne Co., Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) JAN 17 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15 year 1948 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from (Birth) 19 48, to Jan 16th 19 48 that I last saw h. alive on Jan 16th 19 48 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Congenital Atelectasis

Due to Pre Maturity - 7 Months gestation

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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

23. Signature John B. O'Neill (M. D. or other) M.D.
Address 634 North Grand Blvd. Date signed 1/16/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Ernest W. Spillard

Licensed Embalmer No. 4080

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.