

FILED JAN 2 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

3586
State File No. _____
Registrar's No. 1280

Registration District No. _____

Primary Registration District No. 6026

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Sappington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
East Watson Rd., R.R. #12, Kirkwood
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Sappington
(If outside city or town limits, write "RURAL")
(d) Street No. East Watson Rd. R.R. #12, Kirkwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Katherine Straub

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Andrew 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 2 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
87 9 12 hr. _____ min.

9. Birthplace Des Peres, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER
12. Name Hoehne
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Hoffman
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Esther Straub
(b) Address Sappington, Mo.
17. (a) Burial (b) Date thereof 1/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Paul Cemetery

18. (a) Signature of funeral director Louis H. Boop, Inc.
(b) Address 131 W. Argoene Dr. Kirkwood
19. (a) 1-17-48 (b) Carl J. Shapiro
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14
year 1948 hour 4:40 minute _____ M.

21. I hereby certify that I attended the deceased from Jan. 12
1948 to January 14 1948
that I last saw him alive on January 14 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis
Due to arteriosclerosis, generalized
Due to 53
Other conditions _____
(include pregnancy within 3 months of death)

Duration

1 day

PHYSICIAN

Underline the cause of which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

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 Robert M. Tichauer (M. D. or other) M.D.
Address P.O. Box 6 Sappington, Mo Date signed 1-17-48

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

JUL 22 1944

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 Felicitas and

Licensed Embalmer No. 3034

P. O. Address Westwood 22nd

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.