

FILED AUG 11 1948

Registration District No. 119

Primary Registration District No. 4193

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Gasconade  
 (b) City or town Hermann  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Workman Hospital 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12 hours  
Entire Lifetime (Specify whether  
 years, months or days)

3. (a) PRINT FULL NAME Elizabeth Streck

3. (b) If veteran, name war --- 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Geo Streck 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct 13 1875  
 (Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 10 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Gustav Spaete 9

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

14. Maiden name Louise Fitzinger 9

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

16. (a) Informant Theo. Sutter

(b) Address Chapman, Kansas

17. (a) Burial (b) Date thereof 7-25-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Good Hope Cemetery

18. (c) Signature of funeral director Arnold Hummer

(b) Address Morrison Mo

19. (a) 7/24/48 (b) W. M. Munder  
 (Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade  
 (c) City or town Morrison  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
 year 1948 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 22, 1948, to July 23, 1948, that I last saw her alive on July 23, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-vascular accident (stroke, apoplexy) 16hrs  
 Duration

Due to Arterial hypertension, Arteriosclerosis years

Due to \_\_\_\_\_  
 Other conditions Diabetes Mellitus years  
 (Include pregnancy within 3 months of death)

Major findings: None

Of operations None

Of autopsy None

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury 0

23. Signature Cavel T. Shaw, M.D. (M. D. or other M. D.)

Address Hermann, Mo. Date signed 7-23-48

RECEIVED  
District Health Officer No. 9)  
District File Number  
Date Filed AUG 10 1948

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..... *Hugos A. Deener*

Licensed Embalmer No. 3160

P. O. Address Hermann, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.