S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 26 1948

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26622 [redacted]

Primary Registration District No. 1002

Registrar's No. 3155

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
3660 Summitt
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 years (Specify whether years, months or days)

In this community 62 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 5315 Rockhill Rd. 8
(If rural, give location) 0

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country: Austria

3. (a) PRINT FULL NAME: Mr. Ignatz Strauss

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: Widower

6. (b) Name of husband or wife: Sophia

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: August (Month) 5 (Day) 1868 (Year)

8. AGE: Years	Months	Days	If less than one day
79	11	26	hr. min.

9. Birthplace: Austria (City, town, or county) 4 (State or foreign country)

10. Usual occupation: Retired Baker

11. Industry or business:

MOTHER FATHER

12. Name: Frank Strauss

13. Birthplace: Austria (City, town, or county) 4 (State or foreign country)

14. Maiden name: No record

15. Birthplace: Austria (City, town, or county) 4 (State or foreign country)

16. (a) Informant: Mrs. Rose Turner

(b) Address: 5315 Rockhill

17. (a) Burail (Burial, cremation, or removal) (b) Date thereof 8/4/48 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's Cemetery

18. (a) Signature of funeral director: Lucil Van Loan

(b) Address: 20 West Linwood

19. (a) 8-2-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1 year 48 hour 6:00 minute a M.

21. I hereby certify that I attended the deceased from Dec 21, 1947, to Aug 1, 1948, that I last saw him alive on July 20, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic heart disease	1 yr
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Cerebrovascular Accident	4/25/47

Major findings:
Of operations:
Of autopsy: 9 a.m.

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? (Specify type of place)

While at work:

(e) Means of injury: 6

23. Signature: W. T. Hodson M.D. (M. D. or other)

Address: Kansas City 6, Mo. Date signed 8/2/48

(Licensed Embalmer's Statement on Reverse Side) 730 Prof Bg

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 Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Kansas City Mo.

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.