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#32619
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

34736
State File No. _____
Registrar's No. 8896

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME HENRY STRATMAN
3. (b) If veteran, _____ name war _____
3. (c) Social Security No. _____

4. Sex M. O 5. Color W 6. (a) Single, widowed, married, divorced S U
4. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased Aug 9 1865
(Month) (Day) (Year)

8. AGE: 83 Years 2 Months 3 Days If less than one day
hr. _____ min. _____

9. Birthplace Germany (City, town, or county) 4. (State or foreign country)
10. Usual occupation none

MOTHER FATHER
11. Industry or business _____
12. Name Unknown _____
13. Birthplace Germany (City, town, or county) _____ (State or foreign country)
14. Maiden name Unknown
15. Birthplace V. n. _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Jolie Brant _____
(b) Address 1825a Cole St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/48
(Month) (Day) (Year)
(c) Place: burial or cremation St Peter's Cemetery Central Blvd at
18. (a) Signature of funeral director _____
(b) Address 1841 Cass ave
19. (a) OCT 14 1948 (Date received local registrar) (b) J B Rosater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Missouri
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1825a Cole St MEMORIAL 21 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 12th
year 1948 hour 6 minute 45 P.M.
21. I hereby certify that I attended the deceased from 10/10/48
to Oct. 12th 1948
that I last saw him im alive on Oct. 12th 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the esophagus with local invasion Duration _____
Due to _____
Due to H/O
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Same in Oct. 1947
Of operations _____
Of autopsy Same
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 _____
23. Signature Samuel (M. D. or other) _____
Address 1515 Lafayette Date signed 10/13/48

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

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..... *Frank J. Ireland.*
Licensed Embalmer No..... *2646*
P. O. Address..... *Peris*

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.