

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20031**BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 91

1. PLACE OF DEATH a. COUNTY Franklin,		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY Montgomery,	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rhineland, Mo. Rural Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital		d. STREET ADDRESS (If rural, give location) I.S.P.	

3. NAME OF DECEASED (Type or Print) Clarence Benedict Straatmann,	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) June 16th 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Jan 9 1902	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Rhineland, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Leo Straatmann,	13b. MOTHER'S MAIDEN NAME Clotilda Fehlings,	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 486-18-2685	17. INFORMANT'S SIGNATURE OR NAME Greg Lussing, Rhineland	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral bronchopneumonia	DUPLICATE TO (b) Perforated abdominal viscus		3 days
ANTECEDENT CAUSES	DUE TO (c)		17 days
II. OTHER SIGNIFICANT CONDITIONS	DUPLICATE TO (c)		

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-30, 1952, to 6-16, 1952, that I last saw the deceased alive on 6-15, 1952, and that death occurred at 9:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carol T. Shaw, M.D.	23b. ADDRESS Hermann, Mo	23c. DATE SIGNED 6-16-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 18-1952	24c. NAME OF CEMETERY OR CREMATORY Starkenburg	24d. LOCATION (City, town, or county) (State) South of Americus, Mo.
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DATE REC'D BY LOCAL REG. June 16, 1952	REGISTRAR'S SIGNATURE L. J. Hedeman	25. FUNERAL DIRECTOR'S SIGNATURE L. J. Hedeman	ADDRESS Americus, Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed D B Baker

Licensed Embalmer No. 3375

P. O. Address Americus, 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.