

19943

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

No. 300  
10.48

FILED MAY 18 1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 4507

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>St. Louis</u> TOWN		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <u>St. Louis</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>enroute to City Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>239 2016a Senate St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Louise</u> b. (Middle) c. (Last) <u>Strelow</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 1, 1953</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 28, 1881</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Austria</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Not known</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		
14. NAME OF HUSBAND OR WIFE <u>Otto Strelow</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		
17. INFORMANT'S SIGNATURE OR NAME <u>Louise Struharik</u>		ADDRESS <u>1914a Senate St.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Chronic Parenchymatous Degeneration of Eyes</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>General Anoxia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>10 yrs</u> <u>5 yrs</u> <u>6 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4221</u>		
22. I hereby certify that I attended the deceased from <u>April 27, 1953</u> to <u>May 1, 1953</u> , that I last saw the deceased alive on <u>May 1, 1953</u> and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.						
23a. SIGNATURE <u>J. P. Keim</u>		(Degree or title)		23b. ADDRESS <u>2730 McNAIR AVE</u>		
23c. DATE SIGNED <u>May 2, 1953</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>5/4/53</u>		
24c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		24d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>MAY 4 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Gebken Sons</u>		
				ADDRESS <u>2630 Gravois Ave.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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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.....  
Signature of Student Embalmer

Signed *Robert F. Gubke*.....

Licensed Embalmer No. 4144.....

P. O. Address 2630 Gravois A.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.