

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28209

State File No. ....

FILED SEP 6 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6931

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 TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>42 yrs.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Alexian Bros. Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>16 3957 Tholozan</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>FREDERICK</u> b. (Middle) <u>A.</u> c. (Last) <u>STRATE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 7 1955</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 16, 1887</u>		9. AGE (In years last birthday) <u>68 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fixture Company</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Quincy, Illinois</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Henry Strate</u>			13b. MOTHER'S MAIDEN NAME <u>Fredericka Heidkamp</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs. Amanda Muegge Strate</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>494-10-6135</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Amanda M. Strate, 3957 Tholozan 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, asthma, 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> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> ANTECEDENT CAUSES <u>Essential Hypertension</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443 X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?				
22. I hereby certify that I attended the deceased from <u>4-14</u> , 19 <u>55</u> , to <u>8-7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>55</u> , and that death occurred at <u>5:00P</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>John Deert</u> (Degree or title)				23b. ADDRESS <u>3739 Mann</u>		23c. DATE SIGNED <u>8-8-55</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8-10-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>AUG. 9 - 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BEIDERWIEDEN F.H. INC., 1936 St. Louis Ave.</u>				

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

3737 Gravois Ave.  
Phone  
Hours 11:00 to 1:30 PM

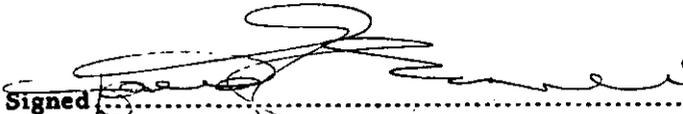
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**STATEMENT BY LICENSED EMBALMER**

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  \_\_\_\_\_

Licensed Embalmer No. 48 J

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