

Health, Welfare, Public Service
 300
 1-56
 ALL diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes.

STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

36261

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9755**

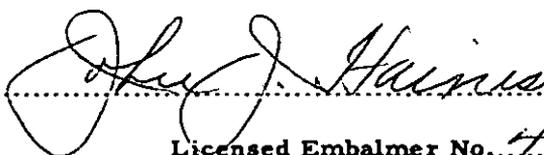
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Warren			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Casco		1090 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hospital			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bernhard Middle Julius Last Stroetker				4. DATE OF DEATH Month Oct. Day 24 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1902		9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Cappeln, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John H. Stroetker				14. MOTHER'S MAIDEN NAME Amalia Schumm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT Address Johanna W. Stroetker, 1505 Race St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure Heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Heart failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic ulcer, left thigh							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			583X				
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY
20f. CITY, TOWN, OR LOCATION		COUNTY			STATE		
21. I attended the deceased from 9/19/56 to 10/24/56 and last saw her/him alive on 10/24/56 Death occurred at 11:50 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) W. B. Kiebler, M.D.				22b. ADDRESS 1007 N. Euclid, St. Louis		22c. DATE SIGNED 10/25/56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-24-56	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Casco, Mo.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington,				25. DATE RECD. BY LOCAL REG. OCT 25 1956		26. REGISTRAR'S SIGNATURE <i>Charles Smith</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

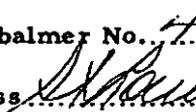
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-
posed by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No.

P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.