

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012362  
STATE FILE NUMBER

FILED APR 9 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3136**

Health,  
Welfare  
Public  
Service

300  
1-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. XIT

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 921A No. 12th, Street</b>				Length of stay in 1b		d. STREET (If outside, give location) ADDRESS <b>25 921A No. 12th St.</b>		
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>H.</b> Last <b>STRAUB</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>16</b> Year <b>1958</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 11, 1894</b>		9. AGE (In years last birthday) <b>63</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vitus Straub</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Startz</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>W W. #1</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Frank Straub 921 No. 12th, Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cancer of Bladder</b> DUE TO (c) <b>Chronic Nephritis</b>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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.) <b>181.0</b>						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			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		STATE		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>10:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deedee or title) <b>Patrick Taylor Carraway</b>				22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>3-18-58</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>March 20-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery Jefferson Barracks, Mo.,</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.,</b>			
24. FUNERAL DIRECTOR <b>Leidner Und. Co 2223 St. Louis Ave</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 18 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		

(Licensed Embalmer's Statement on Reverse Side)

**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. 30

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. -