

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026076

STATE FILE NUMBER

FILED AUG 13 1958 Registration District No. 160 Primary Registration District No. 559V Registrar's No. 109

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JEFF.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RURAL JOACHIM</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>FESTUS</b> <b>0500</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NONE</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>R#1</b>
Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>BARBARA M. STRATMANN</b>			4. DATE OF DEATH Month Day Year <b>7-24-58</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 26, 1869</b>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>HOUSEWORK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>QUINCY, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>GOTTLIEB KAMMERER</b>	13b. MOTHER'S MAIDEN NAME <b>ANNA EITTERLEIN</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If Yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>-----</b>	17. INFORMANT Address <b>ANNA STRATMANN FESTUS, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelo-nephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3+ years</b>
DUE TO (b) <b>Osteo-arthritis</b>		
DUE TO (c) <b>7230</b>		<b>15-years.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arterio-sclerotic heart disease. 2 yrs.</b>		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>-----</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <b>-----</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-----</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>-----</b>
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20d. INJURY OCCURRED WHILE AT <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.) <b>-----</b>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>-----</b>
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21. I attended the deceased from <b>10-4-59 (10-4-49)</b> , to <b>7-24-58</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>7-17-58</b> Death occurred at <b>10:13 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>John F. Rutledge, M.D.</b>	22b. ADDRESS <b>Crystal City, Mo.</b>	22c. DATE SIGNED <b>7-26-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>7-27-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GAMEL</b>	23d. LOCATION (City, town, or county) (State) <b>FESTUS, MO.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>GENTRY R. POLITTE CRYSTAL CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>7-26-58</b>	26. REGISTRAR'S SIGNATURE <i>John A. Taylor</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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JEFFERSON COUNTY HEALTH DEPT.  
HILLSBORO, MISSOURI

DATE RECEIVED

AUG 4 1968

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 Gentry R. Foll

Licensed Embalmer No. 348  
P. O. Address Capital

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.