

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-031228  
STATE FILE NUMBER

FILED SEP 12 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2326

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON FLORISSANT</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>FLORISSANT 4051</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSPITAL</u>		Length of stay in hospital <u>5 DAYS</u> <u>5 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>1435 S. FLORISSANT RD</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>OF</u> Last <u>Strini</u>			4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 13, 1900</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLASTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MUTH PLASTERING</u>		11. BIRTHPLACE (City and state or country) <u>AUSTRIA-HUNGARY</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>GABRIEL STRINI</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
13c. NAME OF HUSBAND OR WIFE <u>JOHANNA STRINI</u>		14. NAME OF HUSBAND OR WIFE <u>JOHANNA STRINI</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>490-12-8397</u>		17. INFORMANT <u>JOHANNA STRINI</u>		Address <u>1435 S. FLORISSANT RD.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis due to arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8/15/58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4200</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Broncho/pneumonia</u>			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.)		
20c. TIME OF INJURY Hour <u>3:30</u> Month <u>9</u> Day <u>6</u> Year <u>58</u> a.m. p.m.	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		

21. I attended the deceased from <u>8-31-58</u> to <u>9-6-58</u> and last saw her/him alive on <u>9-6-58</u> Death occurred at <u>3:30</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. Speno M.D.</u>	(Degree or title) <u>(M.D.)</u>	22b. ADDRESS <u>60150 Brentwood</u>	22c. DATE SIGNED <u>9-8-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>9/10/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR <u>Quadmeyn + Sons</u>	ADDRESS <u>3934 N. 20 ST.</u>	25. DATE RECD. BY LOCAL REG. <u>9-8-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert P. Danke M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 *Herbert J. Gan Jr.* .....

Licensed Embalmer No. *4800* .....

P. O. Address *Kirkwood 227* .....

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.