

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

2736

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis Mo*

Registration District No. *791*
Primary Registration District No. *1003*

File No.
Registered No. *306*
St. Ward)

2. FULL NAME

(a) Residence. No. St. *17* Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Mrs Tillie Strutz*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 9 1870*

7. AGE YEARS MONTHS DAYS IF LESS (than 1 day, ... hrs. or ... min.)
57 3 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Forman*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer *Union Electric Light Co*

9. BIRTHPLACE (CITY OR TOWN) *Ill*
(STATE OR COUNTRY)

10. NAME OF FATHER *Edward Strutz*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

14. INFORMANT *Tillie Strutz*
(Address) *2615 1/2 Tennessee Ave*

15. FILED *9 1928* *May 6 Stark* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 8 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Nov 27* 19*27*, to *Jan 8* 19*28*, that I last saw him alive on *Jan 7* 19*28*, and that death occurred, on the date stated above, at *6:45 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of liver
Hypertension
(duration) yrs. *6* mos. da.

CONTRIBUTORY (SECONDARY) *U4*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF ...
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Xray and lab finding*
(Signed) *H. H. ...* M. D.
Jan 9, 1928 (Address) *3603 2nd St.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Memorial Park Cemetery* DATE OF BURIAL *Jan 10 1928*

20. UNDERTAKER *John J. Robert* ADDRESS *1405 S. ...*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

