

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

Do not use this space.

✓ 37025

1. PLACE OF DEATH

County Callaway Registration District No. 104
Township Fulton Primary Registration District No. 3008
City Fulton (No. Phillip Strauss)

File No. _____
Registered No. 245 St. _____ Ward)

2. FULL NAME

(a) Residence, No. Kansas City, Mo St. 4229 Virginia
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widower</u>
IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>No information</u>		
DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>No information</u>		
AGE	YEARS <u>63</u>	MONTHS <u>+</u>
	DAYS <u>+</u>	If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>scrap iron merchant</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year) <u>A.K.</u>		11. Total time (years) spent in this occupation <u>A.K.</u>
BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No information</u>		
13. NAME <u>No information (Jewish)</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No information</u>		
15. MAIDEN NAME <u>No information</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>No information</u>		
INFORMANT (ADDRESS) <u>State Hospital Records Fulton Mo</u>		
BURIAL, CREMATION, OR REMOVAL		
PLACE	<u>Kansas City</u>	DATE <u>11-22-1931</u>
UNDERTAKER (ADDRESS) <u>J. Louis Funeral Home Kansas City Mo</u>		
FILED <u>Nov 23, 1931</u> <u>R. H. Creese</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-22-1931

22. I HEREBY CERTIFY, That I attended deceased from Nov-29-1930 to Nov-22-1931
I last saw him alive on Nov-22-1931. Death is said to have occurred on the date stated above, at 10:40 P.m.
The principal cause of death and related causes of importance were as follows:
General Paralysis of the Insane Date of onset _____
1930 83

Other contributory causes of importance:
Acute nephritis.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) J. P. Frazer, M. D.
(Address) Fulton State Hospital.



STATE OF MISSOURI

STATE HOSPITAL No. 1

D. H. YOUNG, M.D.
Superintendent

J. J. COREY
Steward

BOARD OF MANAGERS

ROY H. MONIER, *President*
DR. M. A. BLISS
C. F. BLOKER
AUGUSTUS HOCKADAY
THOMAS J. McNAMARA
ALLEN McREYNOLDS

FULTON, MISSOURI

November 27, 1931

Dr. R. N. Crews,
Fulton, Mo.

Dear Doctor:

Enclosed you will find some additional information
about Phillip Strauss.

Yours very truly,


D. H. Young
Superintendent

TRF:LH

Every item of information should be carefully checked and corrected before being placed in the permanent record.

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No..... St..... Ward.....)

2. FULL NAME

Phillip Strauss (Americanized Name)

(a) Residence, No..... St..... 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <i>mal</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Leah Brown</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Oct. 3, 1874</i>		
7. AGE YEARS <i>57</i>	MONTHS	DAYS
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>✓</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>✓</i>	
	10. Date deceased last worked at this occupation (month and year) <i>✓</i>	
11. Total time (years) spent in this occupation.....		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Odesa Russia</i>		
FATHER	13. NAME <i>Abraham Strushgorodsky</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Odesa Russia</i>	
MOTHER	15. MAIDEN NAME <i>Bont Isaac</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Russia</i>	
17. INFORMANT (ADDRESS) <i>Albert G. Strauss (husband)</i>		
18. BURIAL, CREMATION, OR REMOVAL <i>48040th N.C. Mo</i>		
PLACE..... DATE..... 19.....		
19. UNDERTAKER (ADDRESS).....		
20. FILED..... 19..... Registrar.....		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June*, 19.....

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Infarction

Date of onset.....

Other contributory causes of importance: *June*

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

PHYSICIANS should file this certificate with the Registrar.
 If any item of this certificate is missing, the Registrar should be notified immediately.
 If any item of this certificate is missing, the Registrar should be notified immediately.