

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

16526
Do not use this space.

1. PLACE OF DEATH **1939**
 (a) County..... **2** Registration District No..... **791**
 (b) Township..... Primary Registration District No..... **1003** Registered No..... **4060**
 (c) City **St. Louis** (d) Street No. **2145 Mc Causland Ave** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Catharine Straub**
 (a) Residence, No. **2145 Mc Causland Ave** St. **4** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John C Straub**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Mar 21 1860**

7. AGE YEARS **79** MONTHS **1** DAYS **9** IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **At Home**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St Louis Mo**

FATHER 13. NAME **Henry Biermann**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Unknown**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT (ADDRESS) **Ed. Bohlsman #90 Arundel Pl.**

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE **St Peters Cem May 3 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Beiderwieden Funl Home 1936 St. Louis Ave**

20. FILED **MAY 2 1939** **J. F. Brudach** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 30 1939**

22. I HEREBY CERTIFY, that I attended deceased from **Feb 27 1939 to April 30 1939**
 I last saw him alive on **April 29 1939**. Death is said to have occurred on the date stated above, at **8:00 A.M.**
 The principal cause of death and related causes of importance were as follows:
Pulmonary Edema
Chronic Myocarditis
Chronic Mitral Insufficiency
 Other contributory causes of importance:
Arteriosclerosis

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? **No**
 If so, specify _____
 (Signed) **W. C. Henning** M. D.
 (Address) **4548 North Av**

Date of onset **4/28/39**

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

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.

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3737*

P. O. Address *1936 St. Volves Ave*

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 this body is not embalmed, above space should be left blank.