S. No. 2
—11-10-39
. 5-17-39
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FILED APR 15 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9075

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2558

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis

(c) City or town ~~St. Louis~~ WELLSTON NR
(If outside city or town limits write "RURAL")

(d) Street No. 2839 Wheaton Ave
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Janet Joyce Straussner

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 15th (Day) 1940 (Year)

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Arthur Straussner
13. Birthplace St Louis Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Eileen Roberts
15. Birthplace St Louis Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mr Arthur Straussner
(b) Address 2839 Wheaton Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/40 (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Cem

18. (a) Signature of funeral director Stroot - Carroll
(b) Address 4600 Natural Bridge Ave

19. (a) MAR 18 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16th year 1940 hour 1 minute pm M.

21. I hereby certify that I attended the deceased from 3-15, 1940 to 3-16, 1940 that I last saw him alive on 3/16, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Intra-cranial hemorrhage
{ Maternal toxemia of Pregnancy
{ Birth injury

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Intra cranial hemorrhage - Dilatation of stomach - edema of brain

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Joseph A Hardy Jr (M. D. or other) MD
Address 4952 Wary Lane Date signed 3/17/40

(Licensed Embalmer's Statement on Reverse Side)

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. #2265

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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