

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19178

State File No. _____

FILED JUN 3 1944
Registration District No. 37

Primary Registration District No. 2002

Registrar's No. 1209

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
6532 Plymouth
(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 UNIVERSITY CITY
(If outside city or town limits, write "RURAL")

(d) Street No. 6532 Plymouth
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Francis Anna Stronsee

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Carl W. Stronsee 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Nov 18 1897
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>46</u>	<u>6</u>	<u>12</u>	hr. _____ min. _____

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name ELI COOPER

13. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Carl W. Stronsee
(b) Address 6532 Plymouth

17. (a) Burial (b) Date thereof June 1 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Mo

18. (a) Signature of funeral director Jon. W. Clark
(b) Address 1125 Hodiamont Ave

19. (a) JUN 1 1944 (b) E. J. McFarraw, Jr
(Date of issue) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30
year 1944 hour 1 minute 30 P.A.M.

21. I hereby certify that I attended the deceased from 5/15/44
to 5/30/44
that I last saw h. 61 alive on 5/30/44
and that death occurred on the date and hour stated above.

Immediate cause of death Generalized carcinomatosis
Duration 1 1/2 yrs.

Due to _____

Due to 50

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Ca of Breast 1 1/2 yrs ago
Breast removed

Of autopsy None

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) no

(b) Date of occurrence _____

(c) Where did injury occur? home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (c) Means of injury _____

23. Signature Dr. Wm. C. Shaver, M.D. (M. D. number) MLD
Address 61 V.S. - Postman Schavis Date signed 5/31/44

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

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. 3225
P. O. Address 1125 Hadamont Ave St Jo

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, fact should be so stated above.