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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4874**
Registrar's No. **1826**

Registration District No. **818** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 17
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2908 Olive 21
(If rural, give location)
(e) Citizen of foreign country? () (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME George Strong
3. (b) If veteran, U.S. Army 3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 16 day February
year 1945 hour 4 minute 45 P M.
21. I hereby certify that I attended the deceased from

5. Color or race Col
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years

21. I hereby certify that I attended the deceased from

7. Birth date of deceased.....
(Month) (Day) (Year)

that I last saw him..... alive on..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

8. AGE abt 58 Years Months Days If less than one day
hr. min.

Due to Crown Thrombosis
Due to Arteriosclerosis

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

Due to HTA
Other conditions.....
(Include pregnancy within 3 months of death)

10. Usual occupation.....

Major findings:
Of operations.....
Of autopsy.....

11. Industry or business.....

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

12. Name Mr. P. H. ...

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

14. Maiden name.....

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

16. (a) Informant S.W. Bunting
(b) Address 2909 Olive St

17. (a) Burial (b) Date thereof 2/21/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem
(a) Signature of funeral director Pinkie L Toney
(b) Address 3129 Lucas Ave
(a) J. F. Bredeck (b) (Registrar's signature)
(Date received by Registrar) FEB 24 1945

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..... Means of injury.....
23. Signature Patrol E. ... (M.D. or other) 2/21/45
Address Ray, Mo Date signed 2/21/45

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

MOTHER FATHER

1914 H. C.

1826
1914

CAP

1826

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 Clark Young
Licensed Embalmer No. 3371
P. O. Address St Louis

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.

Registration District No. 319

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME

George Strong

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race B

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 58 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation

11. Industry or business

12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. F. Budick
(b) Address _____
19. (a) MAR 15 1945 (b) _____ (Date received local report) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17 day 17 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

4874