

S. No. 2  
M-543  
7-5-17-39  
P I X36571

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5089  
696  
Registrar's No.

FILED FEB 24 1947

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

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

(d) Length of stay: In hospital or institution 2 da. 3 hrs  
(Specify whether years, months or days)

In this community 2 da. 3 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson <sup>48</sup>

(c) City or town Kansas City <sup>3</sup>  
(If outside city or town limits, write "RURAL") <sup>8</sup>

(d) Street No. 812 West 71st St. <sup>0</sup>  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carleton Mark Stratz

3. (b) If veteran, name war — no

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19th  
year 1947 hour 10 minute 05 P.M.

21. I hereby certify that I attended the deceased from 1-17  
1947, to 1-19, 1947  
that I last saw him alive on 1-19, 1947  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: 1 17 1947  
(Month) (Day) (Year)

Immediate cause of death: Psychoblastosis foetalis acie  
Infus + Anemia Birth

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 161

8. AGE:

Years	Months	Days	If less than one day
		<u>2</u>	<u>3</u> hr. min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Charles Roy Stratz, Jr.

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

14. Maiden name Essie Madine Wilson

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

16. (a) Informant Mrs. C.R. Stratz, Jr.

(b) Address 812 West 71st St.

17. (a) Cremation (b) Date thereof 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Luke Hospital

18. (a) Signature of funeral director St. Luke Hospital

(b) Address 44th + Mill Creek R.C. Mo

19. (a) 2-19-47 (b) Geraldine Holme  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy see above

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)

Means of injury 0

23. Signature Rahuel C. Predeen (M.D. or other) MD

Address 315 Alameda Rd AC, Mo Date signed 2/3/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

APR 30 1941

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**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.....

P. O. Address.....

**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.**