

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 21377

FILED JUL 15 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 5907

1. PLACE OF DEATH:

(a) County St. Louis, Mo  
(b) City or town St. Louis, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Baptist Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
65 Years (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Michael Strubel  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Mayme Strubel 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 14, 1883  
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 15 If less than one day hr. min.

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

10. Usual occupation Retired

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

MOTHER FATHER } 12. Name Phillip Strubel 9  
13. Birthplace Unk  
14. Maiden name Margaret Foster (State or foreign country)  
15. Birthplace Unk (City, town, or county) (State or foreign country)

16. (a) Informant Mayme Strubel  
(b) Address City Hospital

17. (a) Burial (b) Date thereof 7 2 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Park

18. (a) Signature of funeral director Sunset Southern Funeral Home  
(b) Address 6322 So. Grand Blvd

19. (a) JUL 2 1948 (b) J. F. Brodeur  
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1619 So. Broadway  
23 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6-29 day 29  
year 1948 hour 10:45 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 6-27, 1948 to 6-29, 1948  
that I last saw him alive on 6-29, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 3 days

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

Due to 107

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 Wm R. Ginn M.D. (M. D. or other)  
Address 2227 S Broadway Date signed 7-1-48

WRITE PLAINLY IN INK

2069

**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 *J. W. Dinkley*

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, Mo.*

**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.**