

S. No. 300  
V. 10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 1 1949

State File No. 39335  
9386

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 0		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural	
c. LENGTH OF STAY (in this place) 1 wk		d. STREET ADDRESS (If rural, give location) KIP House Springs Mo Rt 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		4. DATE OF DEATH (Month) (Day) (Year) 11-18-1949	
3. NAME OF DECEASED (Type or Print) a. (First) Max b. (Middle) S c. (Last) Strolz		5. SEX Male	
6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH 3-14-1874		9. AGE (In years last birthday) 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Max Strolz		13b. MOTHER'S MAIDEN NAME Louise Jannar	
14. NAME OF HUSBAND OR WIFE Anna		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Strolz House Springs Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Decompensated myocardial damage of coronary type ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 9H Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H201		22. I hereby certify that I attended the deceased from 11-12, 1949, to 11-18, 1949, that I last saw the deceased alive on 11-17, 1949, and that death occurred at 2:15 Am., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) No Stergen M.D.		23b. ADDRESS 830 <sup>a</sup> So. Kingshighway	
23c. DATE SIGNED 11/18/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24b. DATE 11-21-49		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
24d. LOCATION (City, town, or county) (State) St Louis Co Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John H Brummer House Springs Mo	
DATE REC'D BY LOCAL REG. NOV 21 1949		REGISTRAR'S SIGNATURE J. D. Carter	

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

9866

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *J Allen Davis Jr* \_\_\_\_\_

Licensed Embalmer No. *4053* \_\_\_\_\_

P. O. Address *St Dennis 10 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.

Apply with