

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19942

FILED JUN 10 1953

State File No.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 5347

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 town or township) St. Louis		c. CITY (If outside corporate limits, write RURAL, and give township) St. Louis	
c. LENGTH OF STAY (In this place) Yrs.		d. STREET ADDRESS (If rural, give location) 5700 Etzel	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5700 Etzel		2057 5700 Etzel	
3. NAME OF DECEASED (Type or Print) a. (First) Augusta		b. (Middle)	
c. (Last) Strauss		4. DATE OF DEATH (Month) (Day) (Year) May 26, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 26, 1885
9. AGE (In years last birthday) 68		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Leopold Marx		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Ludwig Strauss		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Walter Strauss	
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.		17. ADDRESS 5700 Etzel Ave.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anterior desc. heart disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbidity 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from 1948 to May 26, 1953 , that I last saw the deceased alive on May 3, 1953 and that death occurred at 11 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Frank H. Fairley M.D.		23b. ADDRESS 462 No. Taylor	
23c. DATE SIGNED 5/28/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/28/1953	
24c. NAME OF CEMETERY OR CREMATORY Brith Shalom		24d. LOCATION (City, town, or county) (State) University City, Mo.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 28 1953 J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Berger Memorial 4715 McPherson Ave.	

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Guillermo J. Quindria

Licensed Embalmer No. *4229*

Signed
Student Embalmer

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

If, this body is not embalmed, fact should be so stated above.