

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 25 1957

6666

STATE FILE NUMBER

Registration District No. **318**

**318**

Primary Registration District No.

**1003**

Registrar's No. **879**

**879**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Length of stay in lb <b>4 wks. 2 1/2</b>		STREET ADDRESS (If outside, give location) <b>5834 Delor St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>GREEN</b> Last <b>STROHM</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>26</b> Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 16, 1879</b>		9. AGE (In years last birthday) <b>77</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice-President-Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Litchfield &amp; Madison R.R.</b>		11. BIRTHPLACE (City and state or country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Samuel Strohm</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Green</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>707-09-8982</b>		17. INFORMANT <b>Mrs. Ada Strohm</b>			Address <b>5834 Delor St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumothorax, Acute</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 Hrs.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>520X</b>							19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>DEC 21, 1956</b> to <b>JAN. 26, 1957</b> and last saw <b>her</b> alive on <b>AJN. 26, 1957</b> -Death occurred at <b>2:10 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Glover H. O Copher</i>				22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>1/27/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>January 29, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>10180 Gravois ave.</b>			
24. FUNERAL DIRECTOR <b>C. Hofmeister Colonial Mortuary</b> <b>6464 Chippewa St.</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 28 '57</b>		26. REGISTRAR'S SIGNATURE <i>Paul Smith MD</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

