

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3663

STATE FILE NUMBER

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

889

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
38 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. CITY HOSPITAL</u>		Length of stay in 1b	299 STREET ADDRESS (If outside, give location) <u>3900 BATES ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN H STRUCKHOFF</u>			4. DATE OF DEATH Month Day Year <u>JAN 23 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23 1881</u>		9. AGE (In years last birthday) <u>76</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISPATCH RUNNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POST-DISPATCH</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>
13a. FATHER'S NAME <u>BERNARD STRUCKHOFF</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA DOUBECK</u>		14. NAME OF HUSBAND OR WIFE <u>OLLIE STRUCKHOFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>OLLIE STRUCKHOFF 3900 BATES ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>Chr. Myocarditis</u> 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 (a) <u>422.2</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 Death occurred at <u>Jan 11-58</u> to <u>Jan 23-58</u> and last saw him alive on <u>1-15-58</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John Bertl</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>3739 Gravois</u>		22c. DATE SIGNED <u>1-24-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JAN 27 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR <u>Thomas Kutis</u>		ADDRESS <u>2906 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 24 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith</u> <u>MS</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Leo J. Budd*

Licensed Embalmer No. *3989*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.