

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004173

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **130**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 16 1963

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Saint Louis, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Mo. b. COUNTY Saint Louis Co.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN Creve Couer Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthonys Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1574 Ross Road Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED First Joseph Middle Charles Last Strnad			4. DATE OF DEATH Month 1 Day 4 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1914
9. AGE (last birthday) 48		IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY Pharmacy	11. BIRTHPLACE (City and state or country) Saint Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Joseph Strnad	
13b. MOTHER'S MAIDEN NAME Anna Brokowka		14. NAME OF HUSBAND OR WIFE Betty N. Strnad	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT Address Betty Strnad 1574 Ross Road		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA INTERVAL BETWEEN ONSET AND DEATH 4 MO.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 2001		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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 [REDACTED] a.m. p.m.	Month, Day, Year		
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 AUG. 28 '62 to JAN. 4 '63 and last saw him alive on JAN. 2, 1963 Death occurred at 6:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS 6500 CHIPPEWA	22c. DATE SIGNED 1/5/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1-7-'63	23c. NAME OF CEMETERY OR CREMATORY Valhalla	23d. LOCATION (City, town, or county) (State) Saint Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Kriegshauser West 9450 Olive		25. DATE RECD. BY LOCAL REG. JAN 7 1963	26. REGISTRAR'S SIGNATURE [Signature] M.D.

Dr. A. David Hoffmann
6500 Chippewa St
6222 Delon

Fl. 1-2854
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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 William C White

Licensed Embalmer No. 4241

P. O. Address 4228 De Long Highway

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.

Dr. David Hoffman
6500 Chippewa
Fl. 1-2854