

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007380

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 11

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0500
2 4000

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94500

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAR 7 1963

1. PLACE OF DEATH a. COUNTY <u>Jefferson Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HILLSBORO</u>		Length of stay in 1b	c. CITY OR TOWN <u>MATTESE</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CEDAR GROVE NUR. HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>MATTESE SCHOOL Rd.</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA PEARL STROBL</u>			4. DATE OF DEATH Month Day Year <u>FEB - 22 - 1963</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1889</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>HOLTON IND.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>JOHN M^S FATRIDAE</u>	13b. MOTHER'S MAIDEN NAME <u>DELIA FINNEGAN</u>	14. NAME OF HUSBAND OR WIFE <u>ARTHUR STROBL</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or 'unknown') (If yes, give war or dates of service) <u>NO</u> <u>NIL</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>ARTHUR STROBL</u> Address <u>5074 KEMPFB ST LOUIS 26 MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u>		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from June 9, 1961 to Feb 22, 1963 and last saw her alive on Feb. 17, 1963
Death occurred at PO P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert D Sanders M.D.</u>	(Degree or title)	22b. ADDRESS <u>1502 Cass Av</u>	22c. DATE SIGNED <u>2-26-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>FEB-27-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>MATTESE MO</u>
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24. FUNERAL DIRECTOR <u>Fey Funeral Home, MENAVILLE, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>2/26/63</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

MAR 8 1963

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

Gustav W. Dietz

Licensed Embalmer No. 4329

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.