

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009460

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2453

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

COBART  
USE BLACK INK  
OR  
TYPEWRITER RIBBON

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

**FILED MAR 8 1963**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>75 YRS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>ST. LOUIS</b>		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>ST. LOUIS CITY HOSP. # I</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>1406 ANGELICA ST</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>STRAUB</b> Last				4. DATE OF DEATH <b>3-2-63</b>		Month		Day		Year									
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>2/1/1885</b>		9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ST. LOUIS ELECTION BOARD</b>		11. BIRTHPLACE (City and state or country) <b>MARION, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>											
13a. FATHER'S NAME <b>JACOB STRAUB</b>				13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>EDNA STRAUB</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>[REDACTED]</b>		17. INFORMANT Address <b>EDNA STRAUB 1406 ANGELICA ST</b>													
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>carcinoma of lung</b> DUE TO (c) <b>163x</b>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pneumothorax</b>								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 checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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>2-20-63</b> to <b>3-2-63</b> and last saw her/him alive on <b>3-2-63</b>				Death occurred at <b>4:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <b>D. L. Bryant MD</b> (Degree or title)				22b. ADDRESS <b>1515 LAFAYETTE AVE</b>				22c. DATE SIGNED <b>3-2-63</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>2/6/1963</b>		23c. NAME OF CEMETERY OR CREMATORY <b>VALHALLA CEMETERY</b>		23d. LOCATION (City, town, or county) <b>ST. LOUIS CO</b>		23e. STATE <b>MO</b>											
24. FUNERAL DIRECTOR <b>Wiedmeyer &amp; Sons 2924 N. 20 St</b>				ADDRESS		25. DATE RECD. BY LOCAL REG. <b>MAR 4 1963</b>		26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>											

**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 Robert M. Murray

Licensed Embalmer No. 2749

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.