

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050011

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 13132

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 9 1964

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>20 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Anthony Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6415 E. Court</u>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John A. Streicher</u>			4. DATE OF DEATH Month Day Year <u>December 31 1963</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>6/20/03</u>		9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days <u>6 11</u>		IF UNDER 24 HR Hours Min. <u>10 45</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monsanto-Chemical</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Frank Streicher</u>				13b. MOTHER'S MAIDEN NAME <u>Margaret Poetz</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine (Dollie) Streicher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No None</u>				16. SOCIAL SECURITY NO. <u>01</u>		17. INFORMANT <u>Catherine (Dollie) Streicher</u>		Address <u>6415 E. Court</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>UREMIA</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Terminal Congestive Failure</u> <u>Rheumatic Heart Disease</u>										1 MD.	
DUE TO (c) <u>4/6x</u>										10 YRS.	
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 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 <u>12/15/63</u> to <u>12/31/63</u> and last saw her/him live on <u>12/31/63</u> Death occurred at: <u>4:40 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Charles B. Smith M.D.</u>						22b. ADDRESS <u>3438 S. GRAND BLVD</u>			22c. DATE SIGNED <u>1/3/64</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan 4 1964</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>		23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u>		(State)			
24. FUNERAL DIRECTOR <u>Schumacher 3013 Meramec Str.</u>				25. DATE RECD. BY LOCAL REG. <u>JAN 9 1964</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>					

USE BLACK INK OR TYPEWRITER RIBBON

DR. CHARLES LADD ST
3438 S. GRAVOIS

STATE OF ILLINOIS
DEPARTMENT OF HEALTH

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 Jack Haupt

Licensed Embalmer No. 4746

P. O. Address St James 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.