

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

27201
Do not use this space.

1. PLACE OF DEATH **DEED SEP 14 1939** | Registration District No. **791**
 (a) County | Primary Registration District No. **1003** Registered No. **6701**
 (b) Township | City Sanitarium
 (c) City **St. Louis, Missouri** (1) Street No. St.
 (e) Length of residence in city or town where death occurred **19** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Anna Skeeles 420**
 (a) Residence, No. **City Infirmary** St. **13** (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-11-1848**

| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|----------------------------------|
| | 91 | - | 15 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housework**

9. Industry or business in which work was done, as saw mill, bank, etc. **Housework**

10. Date deceased last worked at this occupation (month and year) **About 1920**

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Ohio**

FATHER

13. NAME **W.L. Willigman**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Germany**

MOTHER

15. MAIDEN NAME **Harriett Wells**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown Georgia**

17. INFORMANT **A.K. Busch, M.D.**
(ADDRESS) **5400 Arsenal St**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **St. Louis** DATE **8-1-39**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **W. Richter 3500 Putz**

20. FILE **AUG 1 1939**
J.P. Braddock Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-26-39** 19

22. I HEREBY CERTIFY, That I attended deceased from **7-1-38**, 19, to **7-26-39**, 19.....
 I last saw h. **er** alive on **7-26-39**, 19..... Death is said to have occurred on the date stated above, at **11:10 p.m.**
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis 7-1-38x
Myocardial Degeneration 7-1-38x
Senility 7-1-38x

Other contributory causes of importance:
Senility 7-1-38x

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **Anthony K. Busch**, M. D.
 (Signed) **City Sanitarium**
 (Address) **City Sanitarium**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.