

BUREAU OF THE CENSUS  
SEP 14 1939Registration District No. **791** Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County **ST LOUIS**  
 (b) City or town **ST LOUIS**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **5408 So Broadway 2**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community  
years, months or days3. (a) PRINT FULL NAME **ANNA HAMBUECHEN**3. (b) If veteran, name war **none** 3. (c) Social Security No. **none**4. Sex **female** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**6. (b) Name of husband or wife **NONE** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased **MAR 16 1857**  
(Month) (Day) (Year)8. AGE: Years **81** Months **4** Days **28** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace **ST. LOUIS MO.**  
(City, town, or county) (State or foreign country)10. Usual occupation **HOUSEWORK.**

11. Industry or business \_\_\_\_\_

12. Name **UNKNOWN**13. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)14. Maiden name **UNKNOWN**15. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **John Hoover**(b) Address **5408 So Broadway**17. (a) **CREMATION** (b) Date thereof **AUG. 15**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **MO. CREMATORY**18. (a) Signature of funeral director **J. P. Madell**(b) Address **7128 Michigan**19. (a) **AUG 14 1939** (b) **J. P. Madell**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County \_\_\_\_\_  
 (c) City or town **ST LOUIS** **15**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **5408 So BROADWAY**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **14**  
year **1939** hour **10** minute **10 P.M.**21. I hereby certify that I attended the deceased from **April 1 - 1939**  
~~Aug 14~~ 1939, to **Aug 14** 1939;  
that I last saw her alive on **Aug 14** and that death occurred on the date and hour stated above.Immediate cause of death **Chronic Myocarditis**Due to **arteriosclerosis**Due to **Senility**Other conditions **None**  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? **1** (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_23. Signature **May Marshall** (M. D. or other) \_\_\_\_\_Address **515 1/2 Ave B** Date signed \_\_\_\_\_

Duration

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39  
Form 1 Xesi1

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.

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Jos. P. Fendler Jr.*.....  
Licensed Embalmer No. *925*.....  
P. O. Address..... *St. Louis*.....

**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.**