

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

1008

(a) County St. Louis
 (b) City or town 1
 (c) Name of hospital or institution: Alexian Bros. Hosp.
 (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 days

9. (a) PRINT FULL NAME Frank B. Amann 550

9. (b) If veteran, name war no. 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Amann 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased Aug. 30 1906
 (Month) (Day) (Year)

8. AGE: Years 33 Months 0 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Iron Worker

11. Industry or business 0

MOTHER FATHER { 12. Name John B. Amann 7

13. Birthplace Austria
 (City, town, or county) (State or foreign country)

14. Maiden name Ida Schrecks

15. Birthplace Hannibal Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John B. Amann

(b) Address 4401 Shaw Av.

17. (a) Burial (b) Date thereof 9-5-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Piskens

18. (a) Signature of funeral director With Bros. L & H

(b) Address 2929 S. Jefferson Av.

19. (a) 4 1939 (b) J. J. [Signature]
 (Date of burial) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1
 (c) City or town St. Louis [23]
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1720 S. 14th St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
 year 1939 hour _____ minute 45 Am.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Crownary Sclerosis
Chronic Myocarditis

Due to Indy
 Due to _____

Other conditions 93C
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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? 4

While at work? _____ (Specify type of place) (Specify means of injury)

23. Signature Alfred Perry (M. D. or other) _____

Address Deputy Coroner Date signed 9-4-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Edgar F. With*

Licensed Embalmer No. *2117*

P. O. Address *2929 S. Jefferson Ave*

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.