

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38063  
Registrar's No. 9902

DEC 13 1939 791  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH: 1003  
(a) County 20  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
5612 Finkman  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 1  
(c) City or town St. Louis 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5612 Finkman  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Fred A. Andreas 536  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Elizabeth Andreas 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 1 6 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 18th  
year 1939 hour 4:30 p.m. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 11-18  
1939 to 11-18 1939  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
69 10 12 hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
Coronary atherosclerosis  
Myocarditis chronic  
Due to \_\_\_\_\_

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

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Supt. Bridge & Beach Stove  
Co.  
11. Industry or business \_\_\_\_\_  
12. Name Anthony Andreas 0  
13. Birthplace Unknown Germany 6  
(City, town, or county) (State or foreign country)  
14. Maiden name Pauline Gerler  
15. Birthplace Unknown Germany 6  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy no

16. (a) Informant's own signature Wm. H. S. Halgner  
(b) Address 6709 Leona  
17. (a) Burial (b) Date thereof 11-22-'39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sunset Burial Park

22. If death was due to external causes, fill in the following: no  
(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? \_\_\_\_\_

18. (a) Signature of funeral director Truth Center Mortuary  
(b) Address 4024 Lindell Blvd.  
19. (a) NOV 20 1939 (b) J. B. Beck  
(Date of issue) (Signature)

While at work \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature Philip Schuck (M. D. or other)  
Address 1703 12 Date signed 11-20-39

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

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

*Jack V. Lukens*

Licensed Embalmer No. *4110*

P. O. Address

*4024 Lindell, 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.**