

JAN 12 1940 791
Registration District No. 2000

Primary Registration District No. _____

1. PLACE OF DEATH: 2
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: 4457 Lexington Ave
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days Life (Specify whether)

8. (a) PRINT FULL NAME Anna Varwig 620
8. (b) If veteran, name war _____ 8. (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 _____ 6. (c) Age of husband or wife If alive _____ years
7. Birth date of deceased Nov 27 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 0 18 _____ hr. _____ min.

9. Birthplace St Louis Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation At Home

11. Industry or business _____
12. Name Henry Varwig
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Amelia Steckman
15. Birthplace St Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
(b) Address 4457 Lexington Ave

17. (a) Burial (b) Date thereof 12/18/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Stroot - Carroll
(b) Address 4600 Natural Bridge Ave 446

19. (a) DEC 17 1939 (b) J. T. ...
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County _____
(c) City or town St Louis 10
(If outside city or town limits, write "RURAL")
(d) Street No. 4457 Lexington Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1939 hour 1 minute 15 p. M.
21. I hereby certify that I attended the deceased from Dec 1st
1937 to Dec. 15, 1939;
that I last saw her alive on Dec. 15, 1938
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocarditis 3 yrs.
Due to Multiple Arteritis 8 yrs.
Due to _____

Other conditions Venereal Heming 4 yrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

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? _____ (Specify type of place)
(e) Means of injury 1
23. Signature Edwin ... (M. D. or other)
Address 3635 ... Date signed 12/18/39

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.....

Frank H. Smith

Licensed Embalmer No. 2265

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.