

JAN 12 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41919

Registration District No. 201

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

Registrar's No. 11042

1. PLACE OF DEATH: 2000  
(a) County: 2 St. Louis  
(b) City or town: St. Louis  
(c) Name of hospital or institution:  
4568 Newport Ave.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: \_\_\_\_\_  
(Specify whether  
In this community: Sixty years. years, months or days)

3. (a) PRINT FULL NAME: Anna Streib 361  
8. (b) If veteran, No  
name war: \_\_\_\_\_  
8. (c) Social Security No. None

4. Sex: Female  
5. Color or race: White  
6. (a) Single, widowed, married, divorced: widow  
6. (b) Name of husband or wife: John  
6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: January 20, 1849  
(Month) (Day) (Year)

8. AGE: Years 90 Months EI Days 4  
If less than one day hr. \_\_\_\_\_ min.

9. Birthplace: Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation: Home  
(City, town, or county) (State or foreign country)

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

12. Name: Beschor, Joseph 9

13. Birthplace: Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name: Unknown 1

15. Birthplace: Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: J. Streib  
(b) Address: 4567 Ray Ave.,

17. (a) Burial (b) Date thereof: 12-28-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Pauls Churchyard

18. (a) Signature of funeral director: Wacker-Heldt  
(b) Address: 2331 S. Broadway

19. (a) DEC 27 1939 (b) J. Streib  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: 1  
(c) City or town: St. Louis 15  
(If outside city or town limits, write "RURAL")  
(d) Street No: 4568 Newport Ave.,  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.: 87- years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24  
year 1939 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 22, 1939 to Dec 24, 1939  
that I last saw her alive on Dec 24, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death: Spleen Pneumonia 3 days

Due to: Negative Type

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(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 \_\_\_\_\_

23. Signature: Eduard Weerman (M. D. or other)

Address: 2924 S. Grand Date signed: 12/25/39

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.....

*Robert C. Wheeler*

Licensed Embalmer No. *2128*

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.**