

No. 2  
2-43  
17-39  
X35837

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 1 1944**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

251

Registration District No. **318** Primary Registration District No. **1003** State File No. \_\_\_\_\_ Registrar's No. **809**

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town **St. Louis, Missouri**  
(c) Name of hospital or institution: **St. Louis City Hospital**  
**Max C. Starkloff Memorial**  
(d) Length of stay: In hospital or institution: **40 days**  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **000**  
(c) City or town **St. Louis**  
(d) Street No. **3507 Hogan St., Nebos**  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Anna Disse**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Married**  
6. (b) Name of husband or wife **?** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **?** (Month) (Day) (Year)

8. Age: **72** Years Months Days If less than one day  
**?** hr. min.

9. Birthplace \_\_\_\_\_ (City, town, or county, State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **---**

12. Name **Henry**

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

14. Maiden name **Minnie Opperman**

15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **M. Renard**

(b) Address **City Hospital-1515 Lafayette Ave.**

17. (a) \_\_\_\_\_ (b) Date thereof **1. 27. 44** (Month) (Day) (Year)

(c) Place: **City Crematory**

18. (a) Signature of funeral director **J. W. White**

(b) Address **City Hospital, No. 1**

19. (a) **JAN 28 1944** (Date received local registrar) (b) **J. Z. Bredich** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **13** year **1944** hour **8:10** minute **P** M.  
21. I hereby certify that I attended the deceased from **December 3**, 19**43** to **January 13**, 19**44**  
that I last saw her alive on **January 13**, 19**44** and that death occurred on the date and hour stated above.

Immediate cause of death: **Lobar Pneumonia**

Due to \_\_\_\_\_  
Due to **108**

Other conditions (Includes 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? \_\_\_\_\_ (Specify type of place)  
(e) Manner of injury \_\_\_\_\_  
23. Signature **W. D. Wachs** (Date signed) **1/24/44**  
Address **1515 Lafayette Avenue** Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

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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.....

Licensed Embalmer No.....

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, fact should be so stated above.**