. S. No. 2
0M—2-43
ev. 5-17-39
I. X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25376

State File No.

FILED AUG 24 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 17497

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Isolaton Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12/27/44 (Specify whether years, months or days)
In this community 8/13/45

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2619 Tennessee
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Roberta Anderline.
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 July 17th 1877 (Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days 27 If less than one day hr. min.

9. Birthplace Ferryville (City or town) Wis. (State or foreign country)
10. Usual occupation Housewife.
11. Industry or business
FATHER 12. Name Preston ?
13. Birthplace Unknown (City or town) (State or foreign country)
MOTHER 14. Maiden name Unknown.
15. Birthplace Unknown (City or town) (State or foreign country)
16. (a) Informant Hazel Medina.
(b) Address 5600 Arsenal St.
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove Cem
18. (a) Signature of funeral director Thorkilles Mortuary
(b) Address 290 Gravois Ave
19. (a) AUG 14 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13 year 1945 hour 7 minute 20 P.M.
21. I hereby certify that I attended the deceased from 12/27/44 to 8/13/45 that I last saw him alive on 8/13/45 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myo-Carditis 1945	#1
Due to Hemipligia. 1945	#1
Due to Hypostatic Pneumonia	10 Days

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 Glenn Romain Bowlus (M. D. or other)
Address 5600 arsenal Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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 David Van Fossan

Licensed Embalmer No. 4262

P. O. Address 2906 Grosvenor

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.