

No. 2  
-5-43  
5-17-39  
I X36571

**FILED** APR 17 1946

Registration District No. **310**

Primary Registration District No. **3058-6051**

**1. PLACE OF DEATH:**

(a) County **ST. CHARLES**

(b) City or town **RURAL**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**EVANGELICAL EMMAUS HOME 5**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **6 YRS. 11 Mos. 6 DAYS**  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **ANNA EGGER**

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 **SINGLE**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **APRIL 2 1860**  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<b>85</b>	<b>11</b>	<b>24</b>	hr. _____ min. _____

9. Birthplace **AUSTRIA-4**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Invalid**

11. Industry or business **none**

**MOTHER**

12. Name **UNKNOWN**

13. Birthplace **UNKNOWN** 9  
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

15. Birthplace **UNKNOWN** 9  
(City, town, or county) (State or foreign country)

**FATHER**

16. (a) Informant **Rev. Theophil Stauder**

(b) Address **St Charles Mo.**

17. (a) **BURIAL** (b) Date thereof **March 23, 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Johns.**

18. (a) Signature of funeral director **W. H. ...**

(b) Address **St Charles Mo.**

19. (a) **April 1-46** (b) **K. Annie Hamilton**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **MISSOURI** (b) County **ST. LOUIS 000**

(c) City or town **ST. LOUIS** 17  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) \_\_\_\_\_

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **MARCH** day **26**  
year **1946** hour **2** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **March 1st, 1946** to **March 26th, 1946**  
that I last saw her alive on **March 26th, 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

**Acute dilatation of heart.**

Due to **Chronic myocarditis.**

Due to **Gen. Arteriosclerosis.**

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

Major findings: \_\_\_\_\_

Of operations **no**

Of autopsy **no** **93d**

**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 **W. P. Erick** M. D. or other \_\_\_\_\_  
Address **St Charles Mo.** Date signed **3/30/46**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-16-46

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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.....  
*Arthur J. Bane*

Licensed Embalmer No. 3154

P. O. Address. St. Charles, Mo.

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. 628

Registration District No. 310 Primary Registration District No. 6051

1. PLACE OF DEATH: St Charles  
(a) County.....  
(b) City or town..... Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Anna Egger  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... April 2 (Month) (Day) (Year)  
8. AGE: Years 85 Months Days If less than one day..... hr. min.

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

10. Usual occupation..... Invalid

11. Industry or business..... None

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....  
(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation.....)

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a) June 1 - 26 (b) Fannie Hamilton  
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May 1941 year. hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... to....., 19.....  
that I last saw him..... alive on....., 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

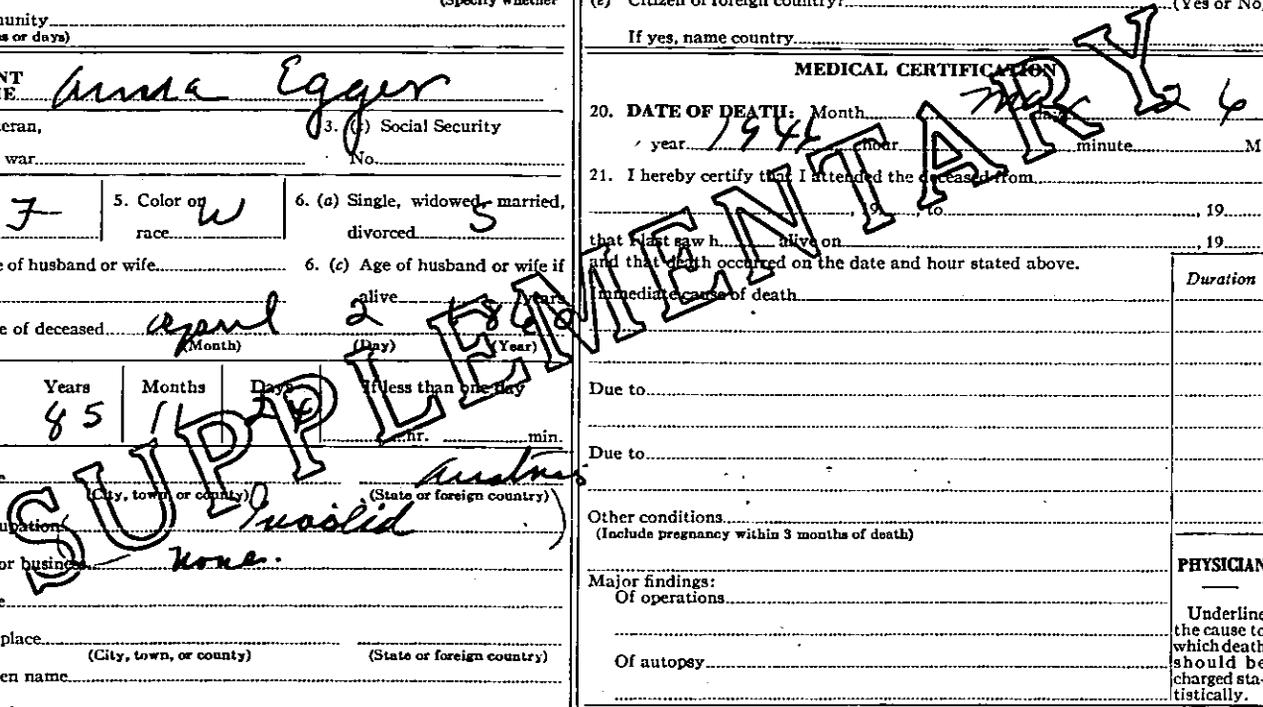
Due to.....  
Due to.....  
Other conditions..... (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
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..... (M. D. or other).....  
Address..... Date signed.....

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



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