

FILED DEC 9 1945

Registration District No. 312

Primary Registration District No. 3069

Registrar's No. 3404

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 7247 Lindell
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Caroline Antk

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 M.
6. (b) Name of husband or wife Chas. Antk 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased Feb. 16 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Tobias Fischer

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

14. Maiden name unknown

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

16. (a) Informant Chas. Antk

(b) Address 7247 Lindell

17. (a) Burial (b) Date thereof 12 3 46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Convent

18. (a) Signature of funeral director Louis H. Buff Jr
(b) Address 1518 Kirkwood

19. (a) 12-2-46 (b) Arthur J. Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 30
year 46 hour 7 minute 30 A.M.
21. I hereby certify that I attended the deceased from 11-27-46
_____ 19____ to 11-30-46
that I last saw h.c. alive on 11-29-46 19____
and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia, st lower
stiel. pneumococci Duration 7 days

Due to arteriosclerotic cardio- weak
vascular renal disease

Due to auricular fibrillation

Other conditions (Include pregnancy within 3 months of death) 1316

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) _____ (b) Means of injury _____

23. Signature Wayne D. Gorla (M. D. or D.O.)
Address 2735 N. Grand Date signed 11-30-46

MOTHER FATHER

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 Peter B. Dubrouille

Licensed Embalmer No. 3691

P. O. Address Richmond Heights

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. *1000*

Registration District No. *317*

Primary Registration District No. *3069*

Registrar's No. *3404*

1. PLACE OF DEATH:

(a) County *St. Louis*

(b) City or town *Richmond Heights*

(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(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

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 _____

3. (a) PRINT FULL NAME *Caroline Auth*

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 *Mar*

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

7. Birth date of deceased *Feb 16 1906*
(Month) (Day) (Year)

8. AGE: Years *83* Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation _____

11. Industry or business _____

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)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) *Caroline J. [Signature]*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year *1946* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I autopsied _____, 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)

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) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

WHILE I LASTLY USE ON ADMIN. DESIGN FOR

38143