

No. 2  
-12-45  
5-17-39  
I X47070

**FILED FEB 3 1947**

**318**

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

**1003**

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.  
(b) City or town St. Louis, Missouri.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or 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 \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3651 Dover Pl.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY ANTHONY

3. (b) If veteran, name war None 3. (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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. Mar. 6 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 10 19 hr. min.

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

10. Usual occupation Housework

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

12. Name Jacob Hampel

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

14. Maiden name Gertrude Heil

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

16. (a) Informant E. Virginia Anthony

(b) Address 3651 Dover Pl.

17. (a) Burial (b) Date thereof 1 27 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old SS Peter & Paul Cem

18. (a) Signature of funeral director Kriegshauser Und. Co.

(b) Address 4228 So. Kingshighway Bl.

19. (a) JAN 25 1947 (b) J. J. Brasch  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25th  
year 1947 hour 2:20 AM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 12/18/47  
\_\_\_\_\_ 19\_\_\_\_ to 12/18/45 19\_\_\_\_  
that I last saw her alive on 12/18/46 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Cerebro-Vascular Accident  
Left Hemiplegia  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions None  
(Include pregnancy within 3 months of death)

Duration  
Since 12-14-46

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? \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature W. Lafayette 1/25/47  
(City, town, or county) (Date signed)  
Address \_\_\_\_\_

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 Richard W. Stovesand

Licensed Embalmer No. 4007

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.**