

No. 2-45
7-39
K47070

FILED JUN 14 1947
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4407 Fair Ave /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Anna Lydia Pieper**

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 **62** years

7. Birth date of deceased **April 9, 1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 1 28 hr. min.

9. Birthplace **St. Louis**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

12. Name **John F. Schnier**

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

14. Maiden name **Anna Tilker**

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

16. (a) Informant **Mr F. Fred Pieper**

(b) Address **4407 Fair Ave**

17. (a) **Burial** (b) Date thereof **6/9/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Math Hermann & Son, Inc**

(b) Address **2161 East Fair Ave**

19. (a) **JUN 9 1947** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Gas**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **4407 Fair Ave**
10 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **6th**
year **1947** hour **11:15 AM** minute _____ M.

21. I hereby certify that I attended the deceased from **April 20**, 19**47**, to **June 6**, 19**47**
that I last saw her alive on **May 21**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Mitral Insufficiency** Duration **2 mo.**

Due to _____

Due to **92** _____
Other conditions **none**
(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) **no**

(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? **no**

Where at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Grace A. Mountjoy** (M. D. or other) **MD**

Address **4032 W. 9th St** Date signed **6/17/47**

WRITE PLAINLY—USE UNFADING BLACK INK—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 *Harold G Burnley*
Licensed Embalmer No. *4302*
P. O. Address *St Paul 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. June
Registrar's No. 5646

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **ST. LOUIS**
(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..... years, months or days)

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

4. Sex F 5. Color W 6. (a) Single, Widow, married, divorced, Widow
6. (b) Name of husband or wife 7. Fred Pieper 6. (c) Age of husband or wife if alive.....
7. Birth date of deceased April 9 (Month) (Day) (Year)

8. AGE: Years 78 Months 1 Days no (If less than one day, give hr. min.)

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

10. Usual occupation.....

11. Industry or business.....

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

18. (a) Signature of funeral director.....
(b) Address.....
19. (a) (Date received local registrar) (b) J. F. Bredek (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 June year 1947 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to.....
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..... (M. D. or other)
Address..... Date signed.....

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

SUPPLEMENTARY

JUL 8 1947

S-19243

e23H.05/