

No. 2
1-17-39

National Office of Vital Statistics

FILED JUN 13 1947

Registration District No. **214**

Primary Registration District No. **1003**

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 **City Infirmary Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12/12/46**
to **5/26/47** (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **STL**
(c) City or town **St. Louis Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **5800 Arsenal St 3134 Lacland**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Anna Vanek**

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 **W**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **April-21-1869**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 1 5 hr. **1/2** min.

9. Birthplace **Checko-Slovakia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business.....

12. Name **Joseph Klouzek**

13. Birthplace **Check-Slovakia**
(City, town, or county) (State or foreign country)

14. Maiden name **Marie**

15. Birthplace **Checko-Slovakia**
(City, town, or county) (State or foreign country)

16. (a) Informant **City Infirmary Records**

(b) Address **5800 Arsenal St.**

17. (a) **Cremation** (b) Date thereof **May 29-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Missouri Crematory**

18. (a) Signature of funeral director **Moydell**

(b) Address **1926 Allen Avenue**

19. (a) **MAY 29 1947** (b) **J.F. Briedeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May**, day **26**, year **1947** hour **12** minute **10** P.M.P

21. I hereby certify that I attended the deceased from **12/12/46** to **5/26 19 47**
that I last saw him **alive** on **5/26 19 47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Broncho Pneumonia** 2 Days.
Cerebral embolism - 83rd 4 Days.
Due to **Senility with Dementia 162A** 2 Yrs.
Arteriosclerotic Heart Disease
Due to **(93d)** Many Yrs.

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations.....
Of autopsies.....
PHYSICIAN
Underline the cause of 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?..... (Specify type of place)

While at work?..... Means of injury.....

23. Signature **M.P. Shover** M. D. or other).....
Address **5600 Arsenal** Date signed **5-26-47**

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

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.....

Me

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Benjamin L. Duncan

..... Licensed Embalmer No. **2272**.....

..... P. O. Address. **1926 Allen Avenue**.....

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. 5327

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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Anna Vanech

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 wid

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
five years

7. Birth date of deceased April 21
(Month) (Day) (Year)

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

9. Birthplace checks
(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.....

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

19. (a) 5-29-1947 (b) J. J. Brubaker
(Date received local registrar) (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 12 minute 00 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..... Duration

Due to.....
Due to.....
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

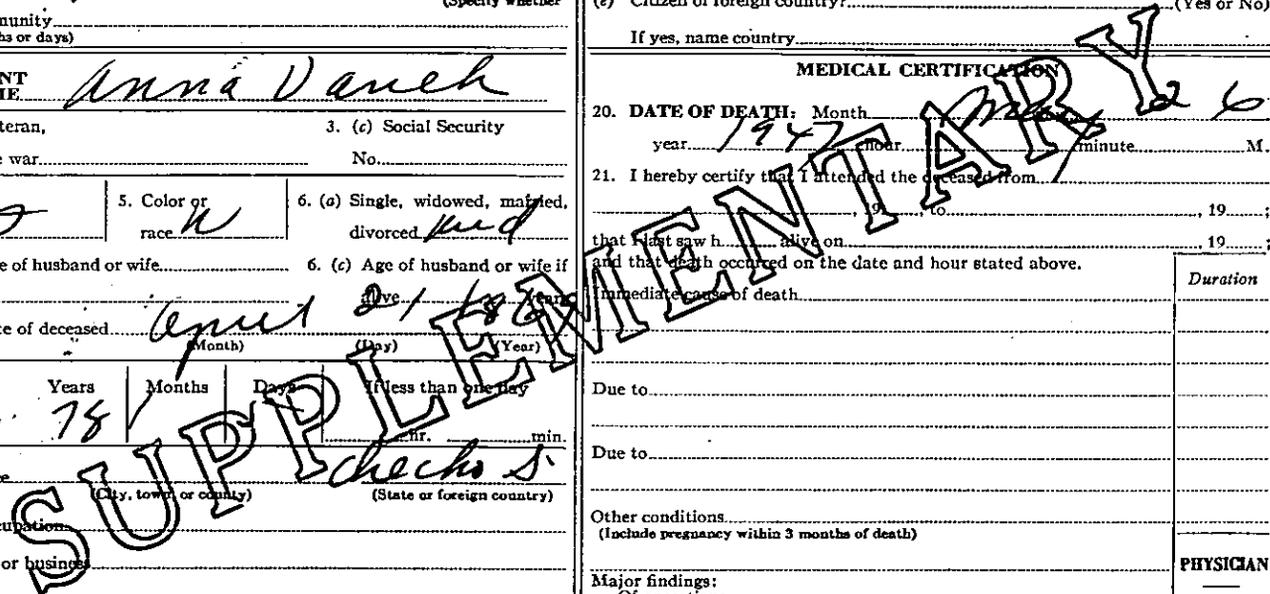
PHYSICIAN

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



S-19453