

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 9 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42966

Registration District No. 318 Primary Registration District No. 100 Registrar's No. 1904

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 3549 Arsenal Albrecht's Hall
(d) Length of stay: In hospital or institution
In this community years, months or days

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

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced S O
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased October 18th, 1894

8. AGE: Years 53 Months 2 Days 7 If less than one day hr. min.

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

10. Usual occupation Sales-Lady Famous-Barr Co.

11. Industry or business

12. Name Charles Doerner
13. Birthplace Germany (City, town, or county) (State or foreign country)

14. Maiden name Barbara Schaaf
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Theodore Eschbach
(b) Address 4807 Rhodes Ave.

17. (a) Cremation (b) Date thereof Dec. 27, 1947
(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Wacker-Heldrich Undertaking Co.
(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) DEC 26 1947 J. F. Brodesch (Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(d) Street No. 4807 Rhodes Ave. 9
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 25th
year 1947 hour 12: minute 05 A. M.

21. I hereby certify that I attended the deceased from 19... 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: Subarachnoid hemorrhage from ruptured cerebral artery
Due to Aneurysm

Other conditions: (Include pregnancy within 3 months of death) 96

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 3
23. Signature Patrick E. Taylor (M. D. or other)
Address Deputy Coroner Date signed

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

Handwritten mark

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..... *Frank J. [Signature]*.....
Licensed Embalmer No. *2675*.....
P. O. Address..... *St. Louis, 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.