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10204

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED APR 12 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. 3301

Registration District No. 318
Primary Registration District No. _____

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:
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 1 Week, (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County _____
(c) City or town St. Louis,
(If outside city or town limits, write "RURAL")
(d) Street No. 4230 Schiller Pl.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd.
year 1948 hour 5: minute 00 AM
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 Carcinoma of Duration
Pancreas Gall, Bladder and Liver - Primary - Liver

Due to _____
Due to Hof
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)
(c) Means of injury 3
23. Signature Patrick C. Taylor (M. D. or other) Sept 6
Address 1500 Clark Ave. Date signed 4/15/48

3. (a) PRINT FULL NAME Anna Gleich,

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 Single,

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

7. Birth date of deceased October 1, 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home,

11. Industry or business _____

12. Name George Gleich,

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

14. Maiden name Anna Zahn,

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

16. (a) Informant Mrs. Cora Traupel,
(b) Address 3423 Wisconsin Ave.,

17. (a) Burial, (b) Date thereof 4/6/48
(Burial, cremation, & removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Gebken-Benz Mortuary
2842 Meramec St.,

(b) Address APR 5 1948
19. (a) _____ (b) J. F. Brudack
(Date received local registrar) (Registrar's signature)

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

623

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..... Joe D. Benz.....

Licensed Embalmer No..... 4249.....

2842 Meramec St.,

P. O. Address..... St. Louis, 18, 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.