

FILED OCT 23 1948 **318**
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(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 **3602a Iowa Ave. /**
(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 **Ida Anton**

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 **Widow 2**

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

7. Birth date of deceased **June 27 1865**
(Month) (Day) (Year)

8. AGE: Years **83** Months **3** Days **18** If less than one day hr. _____ min. _____

9. Birthplace **St. Louis - Mo.** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business _____

12. Name **Carle**

13. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Germany 4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Estelle Anton**

(b) Address **4362 Hollyhills**

17. (a) **Cremation** (b) Date thereof **10-18-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Wm Schmecker**

(b) Address **3013 Neramec St.**

19. (a) **OCT 18 1948** (b) **J. B. Carter**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **San**
(c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **3602a Iowa** **9**
24 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **15**
year **1948** hour **4:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Jan. 1947**
_____ 19____ to **Oct. 15 48** 19____
Oct. 14 48

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Collapsus** **Fuller**
Ch. Myocarditis **several**
Due to _____ **years**
Acute Bronchitis **3 days**

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

Major findings: _____ **PHYSICIAN**
Of operations _____
Of autopsy _____
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 **Dr. P. Young** (M. D. or other) **0**
Address **2621 S. Jefferson** Date signed **10/17/48**

Dr Leo Young
2621 S. Jeff.
LA 3585

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 Francis Williamson

Licensed Embalmer No. 3565

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.