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FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21103

318

1003

State File No.

Registrar's No. 4966

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY Missouri			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		17
d. FULL NAME OF HOSPITAL OR INSTITUTION 3257 N. 20th St.			d. STREET ADDRESS (If rural, give location) 26 = 3257 N. 20th St.		
3. NAME OF DECEASED (Type or Print) a. (First) Anna		b. (Middle)		c. (Last) Hall	
4. DATE OF DEATH (Month) (Day) (Year) June 6, 1949		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Jan. 1, 1866		9. AGE (In years last birthday) 83 IF UNDER 1 YEAR: Months 5 Days 5 IF UNDER 1 HR. Hour 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Brabee		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Charles J. Hall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Florence Pott		ADDRESS 3257 N. 20th St.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic nephritis DUE TO (c) Arterial senile change II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH 2 day 8 years
19a. DATE OF OPERATION no		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 592X	
22. I hereby certify that I attended the deceased from Nov 15, 1948 to Jan 1, 1949 , that I last saw the deceased alive on June 3, 1949 and that death occurred at 10 Am. , from the causes and on the date stated above.					
23a. SIGNATURE Joseph Davie M.D.			23b. ADDRESS 406 Travis Bldg		23c. DATE SIGNED 6-7-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/8/49	24c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE REC'D BY LOCAL REG. JUN 7 1949		REGISTRAR'S SIGNATURE J B Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PROVOST UND. CO., 3710 N. Grand	

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

Dr. J. D. Quire
906 S. Linn
Annapolis, Md.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Albert Mayfield

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3077

P. O. Address _____

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.