

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28093

State File No.

#99146

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>318</u> | | PRIMARY REG. DIST. NO. <u>1000</u> | | Registrar's No. <u>7266</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>City Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MO</u> b. COUNTY <u>St. Louis</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Mo.</u> | | c. LENGTH OF STAY (in this place) <u>11 1/2</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis Missouri</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u> | | | | d. STREET ADDRESS (If rural, give location) <u>1308 1/2 Sidney</u> | | | |
| 3. NAME OF DECEASED a. (First) <u>ANNA</u> | | b. (Middle) <u>Mary</u> | | c. (Last) <u>GRABER</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>August 19th, 1949</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>Aug - Oct - 85</u> | |
| 9. AGE (In years last birthday) _____ | | 10. UNDER 1 YEAR _____ | | 11. UNDER 15 HRS. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (State or foreign country) <u>Edwardsville</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>Unknown</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>August</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter Graber 4645 Newport</u> | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerosis, Generalized</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Impaction of hernia, Diverticulosis, Arterial Hypertension</u> | | | | INTERVAL BETWEEN ONSET AND DEATH _____ | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis MO MO</u> | | | |
| 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? <u>4-5 ft</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>8/15/49</u> , 19 <u>49</u> , to <u>8/19/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8/19/49</u> , 19 <u>49</u> , and that death occurred at <u>5:40pm.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE <u>Joseph J. Alden</u> (Degree or title) _____ | | | | 23b. ADDRESS <u>1515 Lafayette Ave.,</u> | | 23c. DATE SIGNED <u>8/20/49</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>8/23/49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter and Paul</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u> | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>AUG 21 1949</u> | | REGISTRAR'S SIGNATURE <u>J. B. Lusater</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Maydell</u> | | ADDRESS <u>1926 Allen</u> | |

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

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

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

John A. Stammann

Licensed Embalmer No. 4533

P. O. Address 1926 Allen

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.