No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED FEB 2 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3350

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0698

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BARNES HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. LOUIS, 2079
STREET ADDRESS (If rural, give location) 4546 CLAXTON AVE

3. NAME OF DECEASED (Type or Print)
a. (First) ANNA
b. (Middle) AGNES
c. (Last) SOMMER

4. DATE OF DEATH (Month) 1 (Day) 21 (Year) 52

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW
8. DATE OF BIRTH 12/1/1879
9. AGE (In years last birthday) 72 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) ST. LOUIS MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME WILLIAM HORACK
13b. MOTHER'S MAIDEN NAME CATHERINE SUERMEYER
14. NAME OF HUSBAND OR WIFE JOSEPH SOMMERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME MRS MYRTLE CUSIMANO **ADDRESS** 4546 CLAXTON AVE

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) AGNOGENIC MYELOID METAPLASIA — INTERVAL BETWEEN ONSET AND DEATH: SEVERAL YRS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1/14/52
19b. MAJOR FINDINGS OF OPERATION SPLENECTOMY
20. AUTOPSY? YES ☒ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 298.1

22. *I hereby certify that I attended the deceased from* 1/3, 1952, *to* 1/21, 1952, *that I last saw the deceased alive on* 1/21, 1952, *and that death occurred at* 10:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE J. W. Owen Jr. (Degree or title) M.D.
23b. ADDRESS BARNES HOSPITAL
23c. DATE SIGNED 1/21/52

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 1/24/52
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI

DATE REC'D BY LOCAL REG. JAN 23 1952
REGISTRAR'S SIGNATURE J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3077

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.