

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **10577**
2839

FILED APR 12 1952

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
c. LENGTH OF STAY (in this place) 4 yr. 3 mo.		d. STREET ADDRESS (If rural, give location) 13 5800 Arsenal St	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Infirmery.			

3. NAME OF DECEASED (Type or Print) Anthony J. Sewing.			4. DATE OF DEATH (Month) (Day) (Year) March 23, 1952.		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower	8. DATE OF BIRTH Oct. 28, 1874	9. AGE (In years last birthday) 77	10. MONTHS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) St. Louis, Mol		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Henry Sewing	13b. MOTHER'S MAIDEN NAME Charlotte Brum	14. NAME OF HUSBAND OR WIFE 1. Zulah Richardson 2 Mrs. Louise Hoffmeister	
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. 486-74-5953A	17. INFORMANT'S SIGNATURE OR NAME City Infirmery
		ADDRESS 5800 Arsenal St	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5+ years
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 234K

22. I hereby certify that I attended the deceased from Sept. 1, 1950, to Mar. 23, 1952, that I last saw the deceased alive on Mar. 23, 1952, and that death occurred at 5:30 P.M. from the causes and on the date stated above.

23a. SIGNATURE Genze M. Tanaka, M.D.	23b. ADDRESS 5800 Arsenal St.	23c. DATE SIGNED 3-23-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Mar. 26, 1952	24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis Co., MO.

DATE REC'D BY LOCAL REG. MAR 26 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE White Chapel, Ferguson, Missouri.
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(Licensed Embalmer's Statement on Reverse Side)

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *L. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Thigerson, Su*

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.