

FILED MAY 1 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14617
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3735**

1. PLACE OF DEATH
a. COUNTY **11**

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 2169**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Lutheran Hosp.**

d. STREET ADDRESS (If rural, give location) **16 3864 S. Spring Av.**

3. NAME OF DECEASED (Type or Print)
a. (First) **Marie** b. (Middle) **Anna** c. (Last) **Monn**

4. DATE OF DEATH (Month) (Day) (Year)
April 20 1952

5. SEX **Female**

6. COLOR OR RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **widow**

8. DATE OF BIRTH **Dec. 30 1858**

9. AGE (In years last birthday) **93** IF UNDER 1 YEAR Months Days IF UNDER 6 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **At home**

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **Germany**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **George Kuehner**

13b. MOTHER'S MAIDEN NAME **Unknown**

14. NAME OF HUSBAND OR WIFE **Joseph A. Monn**

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. **no.**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Katherine Monn 3864 S. Spring

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Functional Psychosis**

ANTECEDENT CAUSES
DUE TO (b) **Fracture Rt Hip Feb 26 1952**
DUE TO (c) **Alcoholism**

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

INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY? YES NO

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) **Fracture Rt Hip**

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Home 3864 S. Spring**

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) **Feb 26 1952 night**

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? **E9040 21**

22. I hereby certify that I attended the deceased from **Feb 26 52**, 19**52**, to **April 20**, 19**52**, that I last saw the deceased alive on **April 20**, 19**52**, and that death occurred at **6:28** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Emil G. Brust M.D.**

23b. ADDRESS **1901 Cherokee**

23c. DATE SIGNED **4-21-52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Cremation**

24b. DATE **4-23-52**

24c. NAME OF CEMETERY OR CREMATORY **Walhall Crematory**

24d. LOCATION (City, town, or county) (State) **St. Louis Co. Mo.**

DATE REC'D BY LOCAL REG. **APR 21 1952**

REGISTRAR'S SIGNATURE **J. Carl Smith M.D.**

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Witt Brothers 2929 S. Jefferson**

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

168
00

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.....

Harold E. Witt

Licensed Embalmer No. 4353

P. O. Address. 2929 S. Jefferson Ave

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.