

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17725

State File No.

FILED MAY 19 1952

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4392

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis MO</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis MO 2139</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1747 Sublette Ave 13</u>				d. STREET ADDRESS (If rural, give location) <u>1747 Sublette Ave</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anna</u>			b. (Middle) _____		c. (Last) <u>Baskett</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 6 1952</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow 2</u>		8. DATE OF BIRTH <u>about -</u>		9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 6 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St Louis MO. U</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thomas Nunes</u>			13b. MOTHER'S MAIDEN NAME <u>Lizzie Stevenson</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Albert Parker</u>			ADDRESS <u>1747 Sublette</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Mitral Insufficiency</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
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? <u>410X</u>					
22. I hereby certify that I attended the deceased from <u>April 7 - 1952</u> , to <u>May 5 - 1952</u> , that I last saw the deceased alive on <u>5-5-1952</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Dr Edward Beal, M.D.</u>				23b. ADDRESS <u>29019 Saddleburg, 1500 Grand Ave.</u>			23c. DATE SIGNED _____		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-13-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		24d. LOCATION (City, town, or county) <u>St Louis MO</u>		(State) _____	
DATE REC'D BY LOCAL REG. <u>MAY 12 1952</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>4303 Delmar</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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Leroy W. Barnister

Licensed Embalmer No. 4523

P. O. Address. 3880 Easton 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.