

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 22 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6433**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City ospital #1		d. STREET ADDRESS (If rural, give location) 26 2823 North 14th Street.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) ANNA	b. (Middle) E.	c. (Last) THORN	(Month) (Day) (Year) JULY 2, 1952
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 24, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 84 # UNDER: YEAR: Months Days # UNDER: HOUR: Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) Illinois /		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Albert Abler		13b. MOTHER'S MAIDEN NAME Liza Yowell	
14. NAME OF HUSBAND OR WIFE Late E. Thorn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mabel E. Kaimann, 4529 Red Bud Av.	

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) Arteriosclerosis of Heart & Aorta		INTERVAL BETWEEN ONSET AND 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) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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)
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 4200

22. I hereby certify that I attended the deceased from **5-29-52**, 19___, to **7-2-52**, 19___, that I last saw the deceased alive on **7-2-52**, 19___, and that death occurred at **10:45 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dorcas Bailer MD	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 7-3-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 5, 1952	24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. JUL 3 1952	REGISTRAR'S SIGNATURE Charles Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leidner Und. Co. 2223 St. Louis Av.
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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

John P. Buchholz

Licensed Embalmer No. 01674

P. O. Address 2283 Soham Rd

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.