

FILED FEB 2 1954

STANDARD CERTIFICATE OF DEATH

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State File No. 2595 Registrar's No. 0587

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

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, Mo.		c. CITY OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Clinic Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) c. (Last) Boing		4. DATE OF DEATH (Month) (Day) (Year) 1- 19- 54	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH FEB. 8 1872
9. AGE (In years last birthday) 81		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Herman Boing	13b. MOTHER'S MAIDEN NAME Adeline Sermsfled.	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) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ADELINE MARTIN 2628 TAMM

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Generalized Arteriosclerosis	years
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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 442X

22. I hereby certify that I attended the deceased from **June 22, 1953**, to **Jan. 19, 1954**, that I last saw the deceased alive on **Jan. 18, 1954**, and that death occurred at **1:55 A.M.** from the causes and on the date stated above.

23a. SIGNATURE George Esker M.D.	(Degree or title)	23b. ADDRESS 5800 Arsenal Street.	23c. DATE SIGNED 1/19/54
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JAN. 21 1954	24c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. JAN 20 1954	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Garrio
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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.....
Signature of Student Embalmer

Signed *James E. Hill*.....

Licensed Embalmer No. *439*.....

P. O. Address *2906*.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.