

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28818

FILED AUG 20 1954

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6564**

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis c. CITY OR TOWN Affton 4820 d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) 7436 Brightwood Dr.	
3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) T. c. (Last) CHESTNAS		4. DATE OF DEATH (Month) (Day) (Year) July 14 1954	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH March 26, 1892	
9. AGE (In years last birthday) 62		10. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (City and State or Foreign Country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Theodore Gillen		13b. MOTHER'S MAIDEN NAME Christina Dewey	
14. NAME OF HUSBAND OR WIFE Late Andrew Chestnas		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME John W. Chestnas	
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) Brain Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis of cerebral blood vessels DUE TO (c) Generalized Arteriosclerosis	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
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) (m.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X	
22. I hereby certify that I attended the deceased from <u>June 15, 1954</u>, to <u>July 14, 1954</u>; that I last saw the deceased alive on <u>July 14, 1954</u>, and that death occurred at <u>7:15 P.M.</u>, from the causes and on the date stated above.			
23a. SIGNATURE <i>J. J. Roth</i> (Degree or title) M.D.		23b. ADDRESS 634 N. Grand Blvd.	
23c. DATE SIGNED 7-16-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE July 17, 1954		24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	
DATE REC'D BY LOCAL REG. Jul 16 1954		ADDRESS 4228 S. Kingshighway Bl.	

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 *Richard W. Stoverson*.....

Licensed Embalmer No....*400*.....

P. O. Address

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.