

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39369**  
Registrar's No. **8669**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>8669</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>20 hrs.</b>		c. CITY OR TOWN <b>University City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>6815 Plymouth Ave.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b> b. (Middle) <b>P</b> c. (Last) <b>WINER</b>			4. DATE OF DEATH <b>Sept. 20, 1954</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 28, 1882</b>		9. AGE (In years last birthday) <b>72</b> if under 1 year: Months _____ Days _____ if under 14 hrs: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Alton, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>Heinhold Buder.</b>		13b. MOTHER'S MAIDEN NAME <b>Emma F. Scheele</b>		14. NAME OF HUSBAND OR WIFE <b>Charles B. Winer 6815 Ply</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Ym. no. or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Chas. B. Winer 6815 Plymouth Ave</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis &amp; Myocardial Infarction</b> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4201</b>			
22. I hereby certify that I attended the deceased from <b>Aug 2, 1953</b> , to <b>Sept 20, 1954</b> , that I last saw the deceased alive on <b>9/20, 1954</b> , and that death occurred at <b>9:00 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Wm. Weber</b>			23b. ADDRESS <b>MD 1506 Hadamant</b>		23c. DATE SIGNED <b>9/21/54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 23, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Co Mo</b>		
DATE REC'D BY LOCAL REG. <b>SEP 22 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Alexander &amp; Sons 6175 Delmar Blvd</b>			

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

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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..... *Joseph E. McCallahan*

Licensed Embalmer No. *246*

P. O. Address..... *61708*

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.