

42141

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

10918

Registrar's No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |                                  |   |  |   |  |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Missouri</b> |  | b. COUNTY<br><b>St. Louis</b>   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>  |                                  | c. LENGTH OF STAY (in this place)<br><b>11 days</b>   |  | c. CITY OR TOWNSHIP<br><b>Bel Ridge</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Jewish Hospital</b>   |                                  | e. STREET ADDRESS (If rural, give location)<br><b>3225 Welsberg Drive</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)  |                                  | a. (First)<br><b>Bertha</b>   |  | b. (Middle)<br><b>Belle</b>   |  |
|   |                                  | c. (Last)<br><b>Anger</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>11 - 28 - 1954</b>                      |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>8 - 11 - 1894</b> | 9. AGE (In years last birthday)<br><b>60</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>   |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Oklahoma /</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  | 13a. FATHER'S NAME<br><b>Jeremiah Hopkins</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Allie J. Ryan</b>                                   |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>Frank H. Anger</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |
| 17. INFORMANT'S SIGNATURE OR NAME<br><b>Frank H. Anger</b>  |                                  | ADDRESS<br><b>3225 Welsberg Dr.</b>   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute myocardial infarction</b>    |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b>                       |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) <b>Arteriosclerotic coronary thrombosis</b>   |                                  | DUE TO (c)  |  |   | <b>12 days</b>   |
| II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>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) m.  |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                |  | 21f. HOW DID INJURY OCCUR<br><b>42.01</b>   |  |
| 22. I hereby certify that I attended the deceased from <b>11-17, 1954</b> , to <b>11-28, 1954</b> , that I last saw the deceased alive on <b>11/28, 1954</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above. |                                  |   |  |   |  |
| 23a. SIGNATURE<br><b>Stanley W. Hall</b>  |                                  | (Degree or title)<br><b>Med</b>   |  | 23b. ADDRESS<br><b>457 N. Kings Highway</b>   |  |
| 23c. DATE SIGNED<br><b>11.30.54</b>   |                                  |   |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 24b. DATE<br><b>12/1/54</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Lake Charles Cem.</b>                      |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Mo.</b>  |                                  |   |  |   |  |
| DATE REC'D BY LOCAL REG.<br><b>NOV 30 1954</b>  |                                  | REGISTRAR'S SIGNATURE<br><b>J. Earl Smith M.D.</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Drehmann-Harral 1905 Union Blvd.</b> |  |

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

(Licensed Embalmer's Statement on Reverse Side)

Dr. Stanley Wald  
4652 Maryland

1:30- 5PM

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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 *Warren A. Carver*.....  
Licensed Embalmer No. *353*

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.