

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **25555**  
 Registrar's No. **1655**

FILED JUL 26 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

4000  
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <b>St Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>Lemay LOUIS</b>		c. LENGTH OF STAY (in this place) <b>20 day</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mt. St Rose Hospital</b>		c. CITY OR TOWN <b>SAINT LOUIS</b> d. 's Residence within limits of a city as incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <b>5001 Oleatha ave.</b>		2149	
3. NAME OF DECEASED (Type or Print) a. (First) <b>IDA</b> b. (Middle) <b>O</b> c. (Last) <b>ANDERLAN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>7-7-1956</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-16-1877</b>
9. AGE (In years last birthday) <b>78</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Jacob Loehle</b>	
13b. MOTHER'S MAIDEN NAME <b>Johanna Noss</b>		14. NAME OF HUSBAND OR WIFE <b>John Anderlan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>John Anderlan</b>		ADDRESS <b>5001 Oleatha, St Louis, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Pulmonary Tuberculosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <input checked="" type="checkbox"/>	
DUE TO (c) <input checked="" type="checkbox"/>		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None</b>	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?	
22. I hereby certify that I attended the deceased from <b>7/31/56</b> , 19 <b>56</b> , to <b>7/7/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>7/7/56</b> , 19 <b>56</b> , and that death occurred at <b>1:25 AM.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Carroll Schlenker M.D.</b>		23b. ADDRESS <b>3515 South Grand St. Louis</b>	23c. DATE SIGNED <b>7/8/56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-9-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
DATE REC'D BY LOCAL REG. <b>7-8-56</b>	REGISTRAR'S SIGNATURE <b>Herbert A. Dombek</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>HOFFMEISTER COLONIAL MORTUARY</b> ADDRESS <input checked="" type="checkbox"/>	
646 Chippewa Street, St. Louis, Mo. (Licensed Embalmer's Statement on Reverse Side)			

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 *L. C. [Signature]*

Licensed Embalmer No. *1764*

P. O. Address *St. Louis, Mo*

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.