

FILED SEP 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32522

318

1003

8151

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE 720 b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION 5238 Tholozan		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) Zais c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Sept 2 1956	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED widowed	8. DATE OF BIRTH May 12 1879
9. AGE (In years last birthday) 77	10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife	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 Gerhard Middlekamp	13b. MOTHER'S MAIDEN NAME Louisa Taspas	14. NAME OF HUSBAND OR WIFE Albert Zais
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no.	16. SOCIAL SECURITY NO. no.	17. INFORMANT'S SIGNATURE OR NAME Alice Kamp, 5238 Tholozan	
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) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 422.1		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?	
22. I hereby certify that I attended the deceased from 3/22, 1945, to 9/2, 1956, that I last saw the deceased alive on 9/2, 1956, and that death occurred at 8:58 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Robert P. Smith, M.D.		23b. ADDRESS 5203 Chippewa St.	23c. DATE SIGNED 9/5/56
24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE 9-5-1956	24c. NAME OF CEMETERY OR CREMATORY Friedens Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REG. SEP 4 1956	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Griff Bro. & Co. 2929 S. Jefferson	

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 *VE Morris*.....

Licensed Embalmer No. *336*.....

P. O. Address *St. Louis*.....

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.