

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 22 1957

15383

STATE FILE NUMBER

2850

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City ⁰ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital		Length of stay in lb 2 mths.	d. STREET ADDRESS 7619 Lynn (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) ANNABELLE	First ANNABELLE	Middle	Last TODER	4. DATE OF DEATH March 23 1957	Month March	Day 23	Year 1957
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 27 1908	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Eos. Passer	14. MOTHER'S MAIDEN NAME Rose Blocher
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Sam Boder 7619 Lynn	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Rheumatic Valvulitis, inactive</i> <i>myocardial stenosis.</i> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 414X		INTERVAL BETWEEN ONSET AND DEATH 30 yrs.	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour: _____ Month, Day, Year a. m. _____ p. m. _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/6/54 to 3/23/57 and last saw her alive on 3/23/57
Death occurred at 11⁰⁵ AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Monia Ellex MD. (Degree or title)	22b. ADDRESS 601 Humboldt Bldg	22c. DATE SIGNED 3/23/57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Bur.	23b. DATE 3/24/58	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol	23d. LOCATION (City, town, or county) University City, Mo. (State)
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24. FUNERAL DIRECTOR Berger Memorial 4715 McPherson	ADDRESS 4715 McPherson	25. DATE RECD. BY LOCAL REG. MAR 25 57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>
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(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare Public Service

S. 300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by law. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

St. Louis

No.

x University City

x

St. Louis

Mar 21 1925

Jewish Hospital

March 23 1925

March

1925

ANNABELLE

Mar 21 1925

x

female white

USA

St. Louis, Mo.

Housewife

Rose Blocher

Los. Passer

Mar 21 1925

Unk.

Mo

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 *Lawrence J. Davis*

Licensed Embalmer No. 398

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.

Former Memorial A. J. McPherson