Health, Welfare Public Service

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33866

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7774

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 01 3019 Osage St. — Length of stay in 1b: 80 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY:
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3019 Osa ge St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ANNA Middle: L. Last: MEISSBA CH
4. DATE OF DEATH: Month Aug. Day 18, Year 1957
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 6, 1876
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Paul Nahler
14. MOTHER'S MAIDEN NAME: Louise unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --no (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Paul Meissbach, Address: 9028 Kathleen Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 420.0
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 6:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: James M Kelly (Degree or title) Deputy 3
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 8.20.57

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: Aug.21,1957
23c. NAME OF CEMETERY OR CREMATORY: Missouri Crematory
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: BEIDERWIEDEN F.H.Inc. ADDRESS: 1936 St.Louis Ave
25. DATE RECD. BY LOCAL REG.: AUG 20 57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

CORONER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 45

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.