

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041509

STATE FILE NUMBER

FILED DEC 9 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11467

300
1-57

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4530 Gibson Ave. | | d. STREET ADDRESS (If outside, give location) 4530 Gibson Ave. | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle G. East EINSPANIER | | 4. DATE OF DEATH Month Nov. Day 28 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 12, 1870 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Germany |
| 13a. FATHER'S NAME John Bernard Hagemann | | 13b. MOTHER'S MAIDEN NAME Anna Langan | 14. NAME OF HUSBAND OR WIFE Late Herman J. Einspanier |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Address Helen Einspanier 4530 Gibson Ave. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive + Coronary Arteriosclerosis Heart disease. DUE TO (b) Hemiplegia Rt. side DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility | | | INTERVAL BETWEEN ONSET AND DEATH |
| 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 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 Sept. 1957 to Nov 28-1958 and last saw her alive on Nov 27-1958 Death occurred at 12:45 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) Edward H. Jeffers M.D. | | 22b. ADDRESS 3606 Shavois | 22c. DATE SIGNED Nov 28-1958 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Dec. 1, 1958 | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway | | 25. DATE RECD. BY LOCAL REG. NOV 28 '58 | 26. REGISTRAR'S SIGNATURE Carl Smith M.D. |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

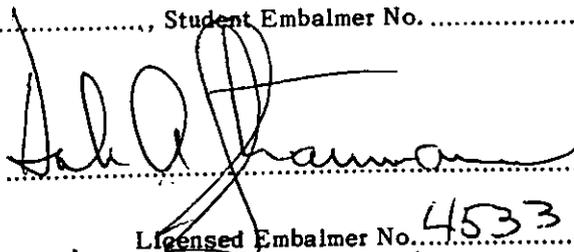
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 ,
Licensed Embalmer No. 4533

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.