URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1959

59-034373 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8395

ENDED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b	c. CITY OR TOWN Overland — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital — Inside Limits Yes ☐ No ☐	d. STREET ADDRESS (If outside, give location) 8657 North Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Anna	Middle	Last: Stratmann	4. DATE OF DEATH Month Day Year: Sept. 9, 1959		
5. SEX: Female	6. COLOR OR RACE: White	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH: 12/29/85	9. AGE (last birthday): 73	IF UNDER 1 YEAR: Months 8 Days 10 — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country): St. Louis	12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13a. FATHER'S NAME: Henry Dedert	13b. MOTHER'S MAIDEN NAME: Catherine Hain		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 488-34-8254	17. INFORMANT: Eugene Stratmann	Address: 3319 McKibbon		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Coronary Art. Occlusion	48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	?
DUE TO (c)	420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐	20a. ACCIDENT ☐ No	SUICIDE ☐ No	HOMICIDE ☐ No	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 9-7-59, to 9-9-59 and last saw ~~him~~ her alive on 9-8-59

Death occurred at 4:50 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John J. Hammond M.D. (Degree or title)	22b. ADDRESS: 634 N. Grand	22c. DATE SIGNED: 9/10/59	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/12/59	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county) (State): St. Louis, Mo.
24. FUNERAL DIRECTOR: Gerald Stuart	ADDRESS: 1225 Union Bl.	25. DATE RECD. BY LOCAL REG.: SEP 11 '59	26. REGISTRAR'S SIGNATURE: Neal Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis M

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