

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-034796

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8814

AMENDED

FILED SEP 27 1961

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Length of stay in 1b <u>8 DAYS</u>	c. CITY OR TOWN <u>LEMAY</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FIRM DESLOGE HOSPITAL</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>112 W. ETTA AV.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>A.</u> Last <u>PEIEFFER</u>			4. DATE OF DEATH Month <u>SEPT</u> - Day <u>19</u> - Year <u>1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1891</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>JOSEPH SCHNELL</u>		13b. MOTHER'S MAIDEN NAME <u>JULIA KASEBAUM</u>		14. NAME OF HUSBAND OR WIFE <u>JACOB PEIEFFER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NIL</u>	17. INFORMANT <u>JACOB PEIEFFER</u> Address <u>112 W. ETTA AVE LEMAY MO</u>		
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) <u>Acute Left Ventricular Failure</u>					<u>10 days</u>
DUE TO (b) <u>Renal Insufficiency</u>					<u>2 months</u>
XXXXX <u>Bronchopneumonia</u> <u>603x</u>					<u>2 days</u>
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N- <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.	Month, Day, Year				
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 <u>Nov. 26, 1957</u> to <u>Sept. 19, 1961</u> last saw her/him alive on <u>Sept. 19, 1961</u> Death occurred at <u>9:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u>		(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>4145 a South Grand Blvd.</u>		22c. DATE SIGNED <u>9. 22. 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>SEPT-23-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE Cem.</u>	23d. LOCATION (City, town, or county) <u>LEMAY, MO</u>		(State)
24. FUNERAL DIRECTOR <u>FEY FUNERAL HOME, MEHLVILLE, MO</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>SEP 22 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 Gustav W. J. [Signature]

Licensed Embalmer No. 4329
P. O. Address St. Louis 91

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.