

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

559
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St. Louis** (d) Street No. **St. John's Hospital** Registered No. **559**
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Clara Ganninger

(a) Residence, No. **4037 Gratiot St.** St. **18**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Edward Ganninger**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Dec. 27, 1891**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 0 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife**
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) **St. Clair** (STATE OR COUNTRY) **Mo.**

FATHER 13. NAME **John Noe**
14. BIRTHPLACE (CITY OR TOWN) **St. Clair** (STATE OR COUNTRY) **Mo.**

MOTHER 15. MAIDEN NAME **Elizabeth Craig**
16. BIRTHPLACE (CITY OR TOWN) **St. Clair** (STATE OR COUNTRY) **Mo.**

17. INFORMANT **Edward Ganninger** (ADDRESS) **4037 Gratiot St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **N. St. Peter & Paul** DATE **1-19-39**

19. FUNERAL DIRECTOR (NAME) **Kriegshauser Mortuary** (ADDRESS) **4228 So. Kingshighway**

20. FILED 19 **J. D. Budick** Local Registrar.

JAN 18 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-16** 19 **39**

22. I HEREBY CERTIFY, That I attended deceased from **1-3**, **189**, to **1-16**, **39**.

I last saw her alive on **1-16**, **1939**. Death is said to have occurred on the date stated above, at **1045**.

The principal cause of death and related causes of importance were as follows:

Pulmonary Embolus Date of onset

Other contributory causes of importance: **Thyroidectomy for hyperthyroidism**

Name of operation **Thyroidectomy** Date of **1-16-39**
What test confirmed diagnosis? **usual** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **no**

By, specify **W. J. Gallagher**, M. D.
(Signed) **W. J. Gallagher**
(Address) **Mo. St. Louis**

No. Theatre B148
Fr 2225 2-4-5

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Edwin M. Bernatt

Licensed Embalmer No. 3024

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 this body is not embalmed, above space should be left blank.