DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUL 11 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24101

Registration District No. 791 1003

Primary Registration District No.

Registrar's No. 6374

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Anthony Hosp - St Louis Mo (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since July 7, 1939 (Specify whether

In this community 36 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4172 Russell (If rural, give location)

(e) If foreign born, how long in U. S. A.? 36 years years.

3. (a) PRINT FULL NAME Anna Killian USA

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank Killian

6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased June (Month) 29 (Day) 1871 (Year)

8. AGE: Years 68 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Clopodia (City, town, or county) Hungary (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name John Weleba
13. Birthplace Hungary (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Junk
15. Birthplace Hungary (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Killian

(b) Address 4172 Russell

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-20-39 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Cemetery

18. (a) Signature of funeral director Witt Bro. L & Nto

(b) Address 2929 S. Jefferson Av

19. (a) JUL 19 1939 (Date received local registrar) (b) J. F. Bradeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17th year 1939 hour 5 minute 50 a. M.

21. I hereby certify that I attended the deceased from 4/13/39, 19, to 7/17, 1939 that I last saw her alive on 7/16, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Post Operative Gall Bladder operation	2 days
Due to	
Due to Cardiac decompensation	1 day
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Chr. cholecystitis cholelithiasis	
Of autopsy None	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Phil H Lherer (M. D. or other) M D

Address 3115 S Grand Av Date signed 7/19/39

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Paul A. Shanklin, Registered Apprentice No. ..... working under my personal supervision.

Signed Paul A. Shanklin

Licensed Embalmer No. 3472

P. O. Address 99998 Jeffers

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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