

SEP 14 1939 791

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar's No. 6911

1. PLACE OF DEATH: 1003  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: City Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution About 8 hours  
 (Specify whether  
 In this community 40 years  
 years, months or days)

3. (a) PRINT FULL NAME Anna Rink 520  
 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 Widowed  
 6. (b) Name of husband or wife Phillip Rink  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Dec. 28 1874  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>64</u>	<u>7</u>	<u>10</u>	<u>hr.</u>	<u>min.</u>

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

10. Usual occupation House work

11. Industry or business Self

MOTHER FATHER  
 12. Name John Wells  
 13. Birthplace Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. A. Davis  
 (b) Address 1215 S. 13th Street

17. (a) Burial (b) Date thereof 8-9-1939  
 (c) Place: burial or cremation New St. Marcus  
 (Month) (Day) (Year)

18. (a) Signature of funeral director J. M. M. Lusk  
 (b) Address 2301 Lafayette Ave

19. (a) AUG 8 1939 (b) J. B. Brueck  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County 1  
 (c) City or town ST. LOUIS 23  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1815 So. 13th Street  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. 40 years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 7 th  
 year 1939 hour 6 minute 20 P. M.

21. I hereby certify that I attended the deceased from 8/7/39 to 8/13/39, 19\_\_\_\_; that I last saw her alive on 8/7/39, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Obesity

Due to \_\_\_\_\_  
 Due to 930  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
 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) N2  
 (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature F. J. Swick (M. D. or other) M. D.  
 Address 1701 No 12th St Date signed 8/8/39

I X1951 USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed

*R. Cooper*

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette Ave

**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.**