DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34221

Registration District No. 201 Primary Registration District No. Registrar's No. 8759

1. PLACE OF DEATH:

(a) County 1008 NOV 13 1939

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

(c) Name of hospital or institution: 3928 Juniata St 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 50 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")

(d) Street No. 3928 Juniata St
(If rural, give location)

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

3. (a) PRINT FULL NAME Anna Jindrich 536

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife William

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

7. Birth date of deceased Jan. 25, 1849 (Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 17 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Bphemia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Bohemia (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Jendrick
(b) Address 3928 Juniata St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/39 (Month) (Day) (Year)
(c) Place: burial or cremation New S.S. Peter & Paul

18. (a) Signature of funeral director W. W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) OCT 14 1939 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 12 year 1939 hour 12 minute 05 A. M.

21. I hereby certify that I attended the deceased from Jan, 1930, to Oct 11, 1939, that I last saw her alive on Oct 10, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis chronic	8 yrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 Julius J. Spuda M.D. (M.D. or other)
Address 23/34 S. 13th St Date signed 10/13/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—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.

I X19511

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 Paul A Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

34221
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 791
(b) Township ..... Primary Registration District No. 1003 Registered No. 8759
(c) City St Louis (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 Anna ~~Jendrich~~ JENDRICH
(a) Residence, No. ..... St. ☐ .....
(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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS 90 MONTHS 8 DAYS 17 If LESS than 1 day, ... hrs. or ..... min.

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.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Anna Jendrich

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12/15/39, 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....
If so, specify .....
(Signed) Julius J. Jenda, M. D.
(Address) 2324 S. 13 St.

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.