

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. **784** Primary Registration District No. **200** Registrar's No. **1792**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **Affton**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
7941 ROCK HILL RD.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **75 years**
 (Specify whether years, months or days)
 In this community **75 years**

NOV 9 1939

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **St. Louis**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **7941 Rock Hill Rd.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **75** years.

3. (a) PRINT FULL NAME **Anna Risch**
 (b) If veteran, name war **none**
 (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **October** Day **11**
 year **1939** hour **9** minute **30** P.M.

4. Sex **female** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **widow**
 (b) Name of husband or wife **Christ** 6. (c) Age of husband or wife if alive **1859** years
 7. Birth date of deceased **Feb. 16, 1859**
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **10-8**, 19**39**, to **10-11**, 19**39**, that I last saw **H** alive on **10-11**, 19**39**, and that death occurred on the date and hour stated above.

8. AGE: Years **80** Months **7** Days **26**
 If less than one day hr. min.

Immediate cause of death **Behaved labor Pneumonia 6 days**
 Duration **6 days**
 Due to **108**

9. Birthplace **Tyrol**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **at home**

Other conditions **old age**
 (Include pregnancy within 3 months of death)

11. Industry or business **none**
 MOTHER FATHER { 12. Name **John Schmidt**
 18. Birthplace **Tyrol**
 (City, town, or county) (State or foreign country).
 14. Maiden name **Elizabeth**
 15. Birthplace **Tyrol**
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations **—**
 Of autopsy **—**
 PHYSICIAN **—**
 Underline the cause to which death should be charged statistically

16. (a) Informant's own signature **Elizabeth Wenger**
 (b) Address **7941 Rock Hill Rd.**
 17. (a) **Burial** (b) Date thereof **Oct. 14, 1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Olive**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **None**
 (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?

18. (a) Signature of funeral director **John F. Ziegenheim**
 (b) Address **7027 Gravois Ave.**
 19. (a) **OCT 12 1939** (b) **J.R. Meyer**
 (Date received local registrar) (Registrar's signature)

While at work? **—** (Specify type of place) (e) Means of injury **—**
 23. Signature **Bernard Plack** (M. D. or other) **—**
 Address **3527 Osage, 4th floor** Date signed **10/12/39**

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.....

C. P. Kidwell

Licensed Embalmer No.....

3877

P. O. Address.....

6937^a Gravo

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.