DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

16675

State File No.

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 4153

1. PLACE OF DEATH:
(a) County St. Louis, Mo. 1
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3yrs. 1mo. 1day (Specify whether
In this community 8 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis 13
(If outside city or town limits, write "RURAL")
(d) Street No. ~~5201 Enright Av~~
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ANNA HAFELI 140
3. (b) If veteran, name war No
3. (c) Social Security No. Unknown
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. 23, 1881 (Month) (Day) (Year)

8. AGE: Years 58 Months 8mo Days 12 If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Bookkeeper & Cashier 7
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Switzerland (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Charlotte Proety
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature L. Deggendorf
(b) Address City Sanitarium
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 5-5-40 (Month) (Day) (Year)
(c) Place: burial or cremation Centralia Ill
18. (a) Signature of funeral director Garnier Funeral Home
(b) Address Centralia, Illinois
19. (a) MAY 9 1940 (Date received local registrar) (b) J. E. Bobbeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5 year 1940 hour 2:05 minute P M.
21. I hereby certify that I attended the deceased from 7-1-39 7-1-39, 19, to 5-5-40, 19;
that I last saw her alive on 5-5-40, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho-Pneumonia (onset 4-15-40) Bilateral	
Due to Fracture of neck of right femur (onset 3-19-40)	
Due to Post-operative infection of right hip (onset 4-9-40)	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186 a 18
Of autopsy No

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) accident
(b) Date of occurrence 3-19-40
(c) Where did injury occur? St Louis Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hospital 13 (Specify type of place)
While at work? (e) Means of injury fall from chair
23. Signature Robert H. Grove (M. D. or other) M.D.
Address 5400 Arsenal St. Date signed 5/5/40

(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.

4153

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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.....John Ketter.....

Licensed Embalmer No.....3880.....

P. O. Address.....

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.