

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 202

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Chesterfield
(c) Name of hospital or institution Olive St. Road
(d) Length of stay: In hospital or institution 4 years
In this community 4 years

8. (a) PRINT FULL NAME ANNA HOLLENBERG-45

8. (b) If veteran, name war none
8. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife William H. Hollenberg (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Feb. 24 1881

8. AGE: Years 59 Months 3 Days 1 hr. min.

9. Birthplace Creve Coeur, Mo. 0

10. Usual occupation Housewife

11. Industry or business

12. Name Charles Kaiser

13. Birthplace Germany

14. Maiden name Marie

15. Birthplace Germany

16. (a) Informant William Hollenberg
(b) Address Chesterfield, Mo.

17. (a) Burial (b) Date of 9-28-40
(c) Place: burial or cremation Zion Lutheran Cem.

18. (a) Signature of funeral director
(b) Address 2504 W. Main, Overland, Mo.

19. (a) MAY 27 1940 (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Chesterfield
(d) Street No. Olive St. Road
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1940 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from April-3-1940 to May 4 1940 that I last saw her alive on May 12 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis

Due to Myo-cardial insufficiency

Due to Aneurysm

Other conditions (Include pregnancy within 3 months of death) 930

Major findings: Of operations
Of autopsy

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?
(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 Wm. Scott (M. D. or other)
Address Bellevue Mo Date signed May 27-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

96

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.