

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **7572**

FILED OCT 25 1940
791

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3550 Hawthorne**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Day**
(Specify whether years, months or days) **abt. 30 yrs**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
Lemay
(c) City or town **0 4656 Oldenburg**
(If outside city or town limits, write "RURAL")
(d) Street No. **40 Yrs.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Steve Anvender**

3. (b) If veteran, **No** name war. _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **Wh** 6. (a) Single, widowed, married **Married**

6. (b) Name of husband or wife **Katherine** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct. 26. 1881.**
(Month) (Day) (Year)

8. AGE: Years **58** Months **10** Days **11** If less than one day hr. min.

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

10. Usual occupation **Carpenter**

11. Industry or business **Odd jobs.**

12. Name **John Anvender**

13. Birthplace **Hungarian** (City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Hungarian** (City, town, or county) (State or foreign country)

16. (a) Informant **Katherine Anvender**

(b) Address **4656 Oldenburg**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Sept. 10. 40** (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive**

18. (a) Signature of funeral director **Fendler Und. Co.**

(b) Address **7420 Michigan Ave.**

19. (a) **SEP 9 1940** (b) **J. J. Rudick** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **8th** year **1940** hour **3:00** minute **A.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Aortitis, Chronic atheromatous with Aneurysm; 2. Cerebral and Pulmonary Edema; Due to 3. Nephritis, Chronic**

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?

While at work? (Specify type of place) (e) Means of injury **5**

23. Signature **Joseph M. ...** (M. D. or other)

Address **...** Date of issue _____

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

MOTHER FATHER

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

Oliver E. Fendler

Licensed Embalmer No.

4148

P. O. Address

Solons, Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30295
Registrar's No. 7572

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3350 Hawthorne
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community abt 30 yr (Specify whether years, months or days)

3. (a) PRINT FULL NAME Steve Amvender

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive 55 years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 11 If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) JAN 9 1941 (b) J F Bredeck (Date received local health) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St Louis
(c) City or town Lemay (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month 9 day 8 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)
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?..... (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 Joseph M. Quinn D. or other) Address Deputy Cor Date signed.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

