

No. 2  
4-12-40  
5-17-39  
I X29159

FEB 25 1941  
Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Enroute City Hospital 3#  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 50 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1000  
(c) City or town St. Louis 1213  
(If outside city or town limits, write "RURAL") 9  
(d) Street No. 1716 Waverly Place  
(If rural, give location)  
(e) If foreign born, how long in U. S. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 9  
year 1941 hour 8 minute 30 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
arteriosclerosis  
Due to Cholelithiasis

Due to Asphyxiation  
Other conditions (Include pregnancy within 3 months of death) None

Major findings:  
Of operations None  
Of autopsy None

Duration

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 Carroll  
23. Signature James F. Brennan (M.D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

3. (a) PRINT FULL NAME ANNA KNOLLMAN  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

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

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 30 1867  
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 10 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Casper Schlester

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

14. Maiden name Unknown

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

16. (a) Informant Anna Lewis

(b) Address 1716 Waverly Place

17. (a) Burial (b) Date thereof Jan 13 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cemetery

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Av. AL14

19. (a) JAN 10 1941 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

**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, fact should be so stated above.**