

No. 2
-13-40
-17-39
X23189

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23298
State File No.
5650
Registrar's No.

FILED AUG 28 1941 791
Registration District No.

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
(c) Name of hospital or institution: Lutheran Hospital
(d) Length of stay: In hospital or institution 0
In this community 0 years, months or days

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

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife G. William Nowotny
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 15, 1867

8. AGE: Years 73 Months 11 Days 21
If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

12. Name Michael Berkerle
13. Birthplace Germany 4
14. Maiden name Katherine Schuster
15. Birthplace Germany 4

16. (a) Informant William Nowotny
(b) Address 4002 Utah Pl.

17. (a) Burial (b) Date thereof July 9, 1941
(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director
(b) Address 1926 Allen Ave.

19. (a) III 8 1941 (b) J. W. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(d) Street No. 1709 S. 11th St. 239
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 6th
year 1941 hour 1 minute 30 P.M.
21. I hereby certify that I attended the deceased from 5/24/41
that I last saw her alive on 7/6/41
and that death occurred on the date and hour stated above.

Immediate cause of death Trauma
Duration 2 Days

Other conditions Ch. hepatitis Endocarditis 5 weeks
Pharyngitis Erysipelas etc. Cerebral hemorrhage (fatal)
12 years (history)
PHYSICIAN

Of autopsy 10
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) 11
(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) (a) Years of injury
23. Signature E. B. Simpson (M. D. or other) J. W. [Signature]
Address 3739 Gravois Ave. Date signed 7/7/41

D. E. Simpson
3137 Grovais

La 4088

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.....

Robert W. Hays
1867

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, fact should be so stated above.