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26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29745

Registration District No. FILED OCT 18 1941 Primary Registration District No. 1003 Registrar's No. 7083

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:
5391 Wells Ave. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

(c) City or town St. Louis 6 18
(If outside city or town limits, write "RURAL")

(d) Street No. 5391 Wells Ave. 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
(If yes, name country) Attending Physician

3. (a) PRINT FULL NAME Anna Scarr

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife William Scarr

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Dec. (Month) 31 (Day) 1863 (Year)

8. AGE: Years	Months	Days	If less than one day
77	8	0	hr. min.

9. Birthplace (City, town, or county) 0 Mo. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry Grobe
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Fredia Wohlbrink
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Dorthea Grobe
(b) Address 5391 Wells Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-41 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.

19. (a) 9/2/41 (Date received local registrar) (b) J. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 31
year 1941 hour 5 minute 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 Sclerosis

Due to Arteriosclerosis

Due to Pending

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature Thomas Kallanan (M. D. or other)
Address Deputy Coroner Date signed 9/2/41

(Licensed Embalmer's Statement on Reverse Side)

10-12

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 Albert R. Thompson

Licensed Embalmer No. 4257

P. O. Address.....

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.