

FILED FEB 1 1943
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 627

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:
4967 Arlington Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4967 Arlington Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

7000
17
9

3. (a) PRINT FULL NAME Anna Kalt

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

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

7. Birth date of deceased..... March 9 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 10 11, hr. min.

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

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Thomas Gavin

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

14. Maiden name..... Sonora Sullivan

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

16. (a) Informant..... Anna Kalt

(b) Address..... 4967 Arlington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof..... 1-23-43 (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... Albert H. Hoppe Inc.

(b) Address..... 4700 Washington Blvd.

19. (a) JAN 21 1943 (Date received local registrar) (b) J. F. Brewster (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Jan day..... 20 year..... 1943 hour..... 10 minute..... 45 P.M.

21. I hereby certify that I attended the deceased from..... Dec 15 to..... Jan 20 19..... 43 that I last saw her alive on..... 1-20-43 19..... and that death occurred on the date and hour stated above.

Immediate cause of death..... Cerebral hemorrhage

Due to..... arteriosclerosis

Due to..... hypertension

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

Major findings: Of operations.....

Of autopsy.....

Duration
4 days

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 name of place) Means of injury.....

23. Signature..... Albert H. Hoppe (M. D. or other) Address..... 5014 Maple Date signed..... 1-21-43

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.....

Alfred G Burnley

Licensed Embalmer No.....

4212

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.