

ED MAY 19 1943 318

State File No.
Registrar's No. **4400**

Registration District No. Primary Registration District No.

1. PLACE OF DEATH:
(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 Mo. 8 Days**
(Specify whether
In this community.....
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. **1035 A. Lafayette Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Anna F. Ruckenbrod**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **-----**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **10**, year **1943** hour **5:50** minute **P.** M.

4. Sex **Female** 5. Color or race **Wht.** 6. (a) Single, widowed, married, divorced **Div.**
6. (b) Name of husband or wife **Adelph** 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Unknown about 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **April 2, 1943** to **May 10, 1943**
that I last saw her alive on **May 10, 1943**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
Abt. 69 Unknown hr. min.

Immediate cause of death **Decubitus ulcer**
Due to.....
Due to.....

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

Other conditions (Include pregnancy within 3 months of death) **1/24**
Major findings: Of operations.....
Of autopsy **Cirrhosis of the liver**

10. Usual occupation **Housewife**

11. Industry or business.....
MOTHER FATHER { 12. Name **John Witak**
13. Birthplace **Unknown** (City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown** (City, town, or county) (State or foreign country)

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

16. (a) Informant **James A. Ruckenbrod**
(b) Address **1033 A Lafayette Ave**

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?

17. (a) **Burial** (b) Date thereof **5/13/43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Matthews**

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

18. (a) Signature of funeral director **W. L. M. M. M.**
(b) Address **1926 Allen Ave.**

23. Signature **Frank Steinberg** (M, D or other) **md**
Address **1515 Lafayette Ave.** Date signed **5/11/43**

19. (a) **MAY 11 1943** (b) **J. P. Bredest**
(Date received local registrar) (Registrar's signature)

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

Form 1001

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 me
....., Registered Apprentice No.....
working under my personal supervision.

Signed Howe L. Moydell
.....
Licensed Embalmer No. 1407
.....
P. O. Address 1926 Allen av
.....

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.