

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

Registration District No. **8 1944** **318** Primary Registration District No. **1003** Registrar's No. **5872**

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:
1207a Emmett Street
(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 **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1207a California Avenue**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Annie Frank**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Fred** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown About 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 63 Unknown _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Frank Besch**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Robert Frank**

(b) Address **4042 California Avenue**

17. (a) **Burial** (b) Date thereof **7/1/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **Wm. C. Maxwell**

(b) Address **1926 Allen Ave.**

19. (a) **JUN 30 1944** (b) **J. J. Bredek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **28th**
year **1944** hour **11** minute **30** AM.

21. I hereby certify that I attended the deceased from **2/28** 19**44** to **6/28** 19**44**
that I last saw her alive on **6/25** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myoplexy** Duration **1 day**

Due to **Cerebral Hemorrhage**

Due to **High tension capitis**
Vascular Disease

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

Major findings:
Of operations _____

Of autopsy _____

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? _____

(e) Means of injury _____ (Specify type of place)

While at work? _____ (M. D. or other)

Address **2924 S. Grand** Date signed **6/28/44**

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

D. M. Davis

Licensed Embalmer No.

3741

P. O. Address

1926 Allen a

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.