

V. S. No. 2
DOM-5-43
Rev. 5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

22799

FILED JUL 26 1944
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6315

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

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:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)

In this community.....
years, months or days

3. (a) PRINT FULL NAME Margaret Editha Anderson

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 W. Robert Anderson

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

7. Birth date of deceased March 15 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 4 1 hr. min.

9. Birthplace Pekin, Illinois.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business.....

MOTHER FATHER

12. Name Emil Berr

13. Birthplace Sommerfelt, Germany. H
(City, town, or county) (State or foreign country)

14. Maiden name Lucinda Killeman

15. Birthplace New Madrid, Mo. O
(City, town, or county) (State or foreign country)

16. (a) Informant Theo. J. Berr, Brother,

(b) Address 1264 Goodfellow Blvd.

17. (a) Burial (b) Date thereof July 19 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery.

18. (a) Signature of funeral director Robt. J. Ambruster,

(b) Address Clayton Rd. At Concordia Lane

19. (a) JUL 17 1944 (b) J. F. Burch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 999

(a) State Florida (b) County.....

(c) City or town Green Cove Springs,
(If outside city or town limits, write "RURAL")

(d) Street No..... (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name Country..... 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1944 hour 9 minute 07 A.M.

21. I hereby certify that I attended the deceased from 7/11/44 19..... to 7/16/44 19.....
that I last saw her alive on 7/16/44 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Repetitive Spasms Disease Cerebral Apoplexy 5 Days

Due to.....

Due to.....

Other conditions Left Hemiplegia
(Include pregnancy within 3 months of death)

Major findings:
Of operations..... 930

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?.....

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

23. Signature C. E. Drape (M. D. or other).....
Address Mo. Pacific Hospital Date signed 7/16/44

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

John Dean Harris

Registered Apprentice No.

363

working under my personal supervision.

Signed

John Fetter

Licensed Embalmer No.

3880

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.